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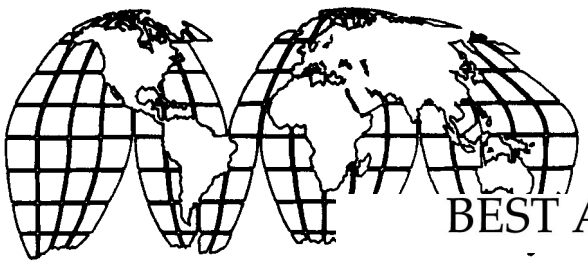

Evaluation of A.I.D. Family Planning Programs

Philippine Case Study

AGENCY FOR INTERNATIONAL DEVELOPMENT

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Evaluation of A.I.D. Family Planning Programs *Philippines Case Study*

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Preface

The current series of field studies of family planning being conducted by the Center for Development Information and Evaluation (CDIE) was initiated in October 1990, with an examination of the Kenya program. In all, CDIE will look at Agency for International Development (A.I.D.) program efforts in six countries: Ghana, Honduras, Pakistan, and Tunisia, in addition to Kenya and the Philippines. The studies focus above the project level and use a common scope of work and format in order to identify broader accomplishments in each country studied. Less attention will be given to inputs and outputs and more attention will be given to *results*. The field studies focus on completed, as opposed to ongoing, programs and projects.

CDIE wishes to thank staff members of the Health and Population Division of USAID/Philippines for their assistance in the planning and conduct of the field study.

Summary

In 1991, as part of a comprehensive evaluation of the Agency for International Development (A.I.D.) family planning programs, the Center for Development Information and Evaluation (CDIE) undertook a field assessment of the family planning program in the Philippines. A CDIE evaluation team visited the country and conducted in-depth interviews with senior Government officials, A.I.D. staff, project and program staff, population experts, officials of nongovernmental organizations (NGOs), and targeted clients. The evaluation team also systematically reviewed and analyzed program records, documents, and data.

Origin and Development of the Family Planning Program

In 1969, faced with rapid population growth, the Government of the Philippines appointed a population commission (POPCOM) to study the problem and make suitable recommendations. After the commission submitted its report, the Government gave POPCOM permanent status in the Office of the President and entrusted it with the responsibility of designing and coordinating national population policy. Consequently, POPCOM formulated a population policy, proposed specific demographic targets, and assumed a leadership role in the family planning program.

During the early 1970s, the Government followed a clinic-based approach and actively promoted all family planning methods with the exception of abortion. It amended income tax and labor laws to encourage small families. It also modified the Philippine Medicare Law to allow Medicare reimbursements to participating physicians and institutions for voluntary sterilizations. The Government formed a partnership with Philippine voluntary organizations.

In 1976, an analysis of a National Demographic Survey indicated that while 70 percent of the population lived in rural areas, nearly all clinics were in towns. On the basis of these findings, the Government launched a comprehensive community-based distribution system (CBD) called Outreach. Under this system, a "supply point" was established in each of 52,000 *barangays* (villages), with a volunteer worker to motivate and supply contraceptives to residents. Barangay

volunteers were supervised by full-time workers, who recruited volunteers and prescribed pills and nonsurgical contraceptive methods.

The growing popularity of family planning, particularly of voluntary surgical contraception (VSC), caused apprehensions among Catholic Church leaders. They felt that the promotion of artificial birth control methods would corrupt "impressionable youth" and eventually lead to the legalization of abortion. In 1978, partly because of the opposition of the Catholic Church and more widespread criticism of the population targets set by POPCOM, the Government accepted the recommendation of a review committee that the program shift its emphasis from fertility reduction to family welfare. It also eliminated demographic targets from national 5-year plans.

During the early 1980s, the Government implemented the population program with considerably less enthusiasm, due in large part to economic stagnation, growing political discontent, and the continuing opposition of the Catholic Church hierarchy. Because it had been so closely identified with the chief of state, the program suffered a serious setback with the fall of the Marcos regime in 1986.

The new Government was initially indifferent, if not hostile, to the existing population policies and programs. It deleted the population control mandate given in the 1973 Constitution, and, at the insistence of Catholic Church leaders, inserted a clause to "equally protect the life of the mother and the life of the unborn from conception." Subsequently, the Government issued a new population policy emphasizing child spacing and not fertility reduction per se, rights of married couples to determine family size, and the rejection of abortion as a means of controlling fertility. The Government transferred program direction to the Department of Health, but failed to provide resources sufficient to maintain program performance levels.

A.I.D. Assistance

In furnishing about $100 million from 1968 to 1988, A.I.D. has been the single most important external contributor to the Philippine family planning program. It met 58 percent of the total family planning expenditures during the first 5 years, when planning was gaining a foothold. Between 1970 and 1988, when external agencies accounted for nearly 57 percent of total program expenditures, A.I.D. was supplying two-thirds of that amount. Both critics and supporters agree

that A.I.D. assistance has been critical for the program's continuation and growth. A.I.D. assistance was channeled through three large projects.

The first project, Population Planning I (1970–1976), was signed within a year of the establishment of POPCOM. It provided funds to train staff for Department of Health and NGO clinics, to support the establishment of 2,400 family planning service units and 11 POPCOM regional offices, and to promote voluntary surgical contraception units in 35 hospitals and 456 units in nonhospital settings. Later, when Outreach was implemented, project funds were also used to train 513 district population officers, 3,103 full-time Outreach workers, and 77 trainers.

A.I.D.'s second project, Population Planning II (1977–1980), was designed to provide funding for implementing Outreach, which received 75 percent of its funds. Its major emphases were voluntary surgical sterilization, a logistics support system that reached 52,000 barangay supply points, and an Information, Education, and Communications system for full-time Outreach workers.

A.I.D. initiated its third project, Population Planning III (1980–1986), when it became apparent that adequate funds for Outreach would not be forthcoming from local sources. This 5-year project budgeted $30 million in grant funds and $27 million in loans, intended for salaries, training, and travel expenses for 3,000 full-time field-workers and 600 population officers; upgrading of Department of Health regional centers; reimbursement of clinic costs for VSC; innovative efforts by private and public sectors; operations and research; and an improved management information system (MIS).

When the project ended, A.I.D. used unexpended funds to support family planning activities of NGOs and to strengthen the operational capacity of the Department of Health. It also used centrally funded projects to initiate new efforts and strengthen old ones.

Program Effectiveness

The program succeeded in building a delivery system which provided easy access of the target group (married couples of reproductive age) to affordable contraceptive services.

Outreach, though it fell into disarray in the late 1980s, helped transform what was essentially urban, clinic-based distribution into a national program. It achieved

a remarkable access level of one service point for every 99 married women of reproductive age. As a result, over 30 percent of users obtained supplies from Outreach points. In terms of access, then, Outreach earned high marks; far higher, for example, than the program in Indonesia, where only 19 percent of acceptors received supplies through CBD, or Thailand, where only 10 percent were reached.

Nevertheless, with respect to questions of access to and availability and use of contraceptive services, the Philippine family planning program had its shortcomings. One was that training of field-workers failed to provide sufficient knowledge of contraceptives and the relative effectiveness of different methods. Workers were as likely to promote condoms as IUDs, and rather than teaching the health benefits of child spacing and limiting, their instruction stressed the potential health contraindications of contraceptives, particularly pills and IUDs.

Had field supervision been strong and frequent, the effects of inadequate training could have been overcome to some extent. Unfortunately, this was not the case due to the lack of technically qualified supervisors and the absence of a well-defined authority structure. Field-workers were not under a unified command: POPCOM retained technical direction while local government units had administrative control. Moreover, contraceptive supplies were provided by POPCOM but referrals for specialist services were made to Department of Health clinics.

The effectiveness of the program was also undermined by the "target" incentive system that rewarded field-workers only for attracting new acceptors and not for continued use of contraception by existing clients. The problem was further compounded by the fact that even individuals who changed from an effective to a less effective method were counted as "new" acceptors.

Efficiency

There is little doubt that the cost of the program, particularly Outreach, has been quite high, especially because no users' fees were charged for services. The Project Paper for Population Planning III recognized this problem and proposed pilot studies to explore low-cost alternatives. No such studies were conducted, however.

CDIE examined efficiency, first through analysis using the FamPlan System of Models, in which a scenario of "no family planning program" was compared with the "with family planning program" (i.e., the Philippine national planning program). The FamPlan analysis showed that when health, education, and other social service expenditures were aggregated and the "with family planning program" compared with the "without family planning program," annual savings exceeded annual family planning costs by 1978, and cumulative savings exceeded cumulative costs by 1982. Even when benefits (reductions in total social sector expenditures) are discounted at 15 percent per annum, break-even is achieved by 1985. Assuming no increase in prevalence and a 10 percent discount rate, FamPlan calculated a 5 to 1 benefits-cost ratio by the year 2000.

Second, the study examined how certain changes in program organization and operations could have brought about greater efficiency. One example was the indication that poor method selection, plus a 50 percent drop out rate among pill users, could have been corrected if not largely avoided had field-workers been better trained to steer people away from the less effective methods. Another example related to the adoption of VSC, which at $12 per procedure was below the average world cost, yet efficiency would have been greater if larger numbers of Filipino acceptors had adopted VSC after the birth of their third child, instead of waiting until the fourth or higher-order birth.

Sustainability of the Program

Sustainability of a program depends on several factors, particularly political commitment, efficient management, effective delivery systems, and, above all, sufficient funding. As of 1988, the sustainability of the population program was in doubt. It did not enjoy strong support from the Government or powerful political leaders. Although the Government had a small, experienced, and dedicated cadre of officers in the Department of Health and POPCOM, the staff became demoralized. The usually active NGO community had not been able to raise resources locally. And most important, the Government had not made an attempt to establish a sustainable financing strategy for the program. As a result, the program in its present form did not become financially sustainable; that is, it was unable to continue without external assistance.

Longer-Term Effects

Available data indicate that the country has made progress.

First, there has been a decline in population growth rates. From 1960 to 1970, the country's population increased from 27.1 million to 36.7 million, an average annual growth rate of 3.0 percent. By 1980 it had reached 48.1 million, with an annual growth rate of 2.7 percent during the 1970s. Preliminary results from the 1990 census give a total of 60.7 million, for a growth rate of 2.3 percent during the 1980s.

Second, total fertility rates (TFR) have been declining. If a TFR for 1970 is taken as a baseline figure, during the subsequent 15 years the TFR declined from 6.18 to 4.26, or nearly 31 percent.

Third, contraceptive prevalence has increased from the beginning of the program. The prevalence of modern methods with high use effectiveness (pill, IUD, and female sterilization) increased by about 1 percent annually, from 2 percent in 1968 to 21 percent in 1988. Female sterilization was the most favored method, with a 20-year increase from 0 percent to about 11 percent of currently married women, but virtually all of the increase in the use of this method occurred between 1973 and 1983. The use of the pill was stable at a level of approximately 6 percent since 1973. The IUD remained stable at a very low level of approximately 2 percent.

The percentage of Filipinos using less efficient program methods (rhythm and condoms) showed little change; rhythm increased from 6 percent to only 8 percent, and condoms from 0 percent to just 1 percent, despite massive efforts to promote these two methods. The percentage of married women using nonprogram methods (primarily withdrawal) showed little change throughout the interval, remaining in the vicinity of 6 percent.

The data presented above, together with the interviews conducted by the evaluation team, led to several additional findings concerning the longer-term effects, or impact of the program.

First, the use of the three reversible methods—pills, condoms, and IUDs—that apparently appealed to only a small fraction of couples, hovered in the vicinity of 10 percent (combined) through a 15-year interval, and nearly 30 percent of the pills and condoms were obtained commercially rather than through

the program. The lack of appeal of these methods has also been reflected in higher discontinuation rates in the Philippines than in neighboring countries.

Second, as a related point, the program was not effective in increasing demand for these reversible methods. They were available at no charge to large numbers of potential users from the mid-1970s until the late 1980s. However, economic development, often a source of demand, was not taking place, especially in rural areas; apparently the program was unable to act independently of the economic situation to generate demand.

Over the years, little notice has been taken of the absence of any increase in the demand for modern reversible methods. Probably the main reason is that the distribution of large quantities of supplies and other program outputs was required simply to maintain the status quo, that is, the prevalence level that existed in 1973. Moreover, the number of so-called new acceptors has always been large because of the unusually high drop out rate and the subsequent reinstatement of these dropouts as new acceptors. The total number of new acceptors and continuing users has indeed increased over time, although simply in proportion to the increases in the population at risk.

Third, the impact of the program lies mainly in whatever contributions it has made to the use of female sterilization and rhythm. These are the only program methods to show evidence of increasing use and demand. The role of A.I.D. has been substantial in the training of doctors and nurses in surgical sterilization and the Outreach program unquestionably helped to motivate use of this method. A high proportion of tubal ligations were carried out at NGO clinics, and, similarly, it is mainly NGOs that promoted the various forms of rhythm.

Conclusions

1. A major conclusion is that over the 20-year period under study, the family planning activities supported by USAID/Philippines and those of the Philippine national program were virtually indistinguishable. A related conclusion is that when a donor gets this closely identified with a partner country effort, it shares both the credit and criticism for what transpired.

2. The evaluation showed that neither the Government nor A.I.D. was able initially to approach Philippine population issues in terms of committing re-

sources and being engaged over many years in what might be termed an intergenerational program. The experience of the Philippines, together with what we have learned elsewhere about family planning, confirms that creating an effective, efficient, and sustainable family planning effort is not a one- or two-project undertaking. Long-term commitment makes possible the creation of a multiyear strategic plan, in which other donors are encouraged to participate in specific ways.

3. Funding for training ended too soon; by 1988 normal attrition and emigration had reduced the ranks of workers at all levels, seriously undercutting program sustainability. Moreover, training was uneven in quality. For example, despite recurrent reports of failure of training to equip field-workers to improve their performance, their training programs changed very little. There is no evidence that changes were made in training to solve the three continuing problems of high drop out rates, knowledge-practice gaps, and choice of ineffective contraceptives.

4. NGOs have been very important in initiating and sustaining family planning in the Philippines, serving as the earliest advocates, before the national program began, and continuing a constructive involvement to the present. NGOs have been the principal institutional force for innovation and training outside the Government. They were especially influential in pioneering the use of VSC. Similarly, it was mainly the NGOs that promoted the various forms of the rhythm method and initiated adolescent fertility projects that focused on sex education. They led the way in the rapid expansion of clinical services, maintained qualified staffs and adequate supplies, and stayed open 7 days per week.

On the one hand, the CDIE team concluded that had the Government, A.I.D., and other donors planned for the best utilization of the NGOs, capitalizing on their substantial strengths and finding ways to compensate for their weaknesses, these organizations might have been even more effective. On the other hand, it is reasonable to conclude that had these private sector organizations not participated in family planning, the Philippines program would have enjoyed much less success, and might have disappeared altogether.

5. A sustainable financial strategy was never developed. From its beginning, the Philippine family planning program lacked adequate in-country resources to cover recurrent costs. External funding supported 85 percent of expenditures during the program's first 4 years, and, without it, the program could not have

begun when it did. Donors provided almost 57 percent of total program expenditures from 1970–1988, of which A.I.D. contributed 70 percent.

The Philippine experience leads to the conclusion that for family planning programs to achieve sustainability—managerial, institutional, and financial—host countries and donors have to plan for and pursue this objective systematically. The related conclusion is that developing countries cannot bear an increasing part of the burden of financing a massive family planning program without sustained economic growth.

6. The study concluded that each element of the program should have had targets that went beyond immediate outputs—such as training a specified number of personnel or distributing a specified number of condoms each year. The Philippine program tended to set goals independent of any evidence that they could be achieved, with resulting damage both to the credibility of the program and to staff morale. The CDIE team concluded that much of this damage could have been avoided if targets had been set based on more direct evidence of possible change.

7. From the beginning of the program, A.I.D. was inconsistent if not ambivalent on the establishment of the management information system. While it repeatedly emphasized the importance of the MIS, it did not take action to ensure that it was implemented. This poor performance was matched by A.I.D.'s inconsistency with respect to financial efficiency measures. Regular and systematic cost analyses, despite having a high priority with A.I.D., were not conducted. Consequently, timely corrective measures could not be taken to improve program performance.

The CDIE team concluded that because there was never a longer-term research plan, performance indicators did not receive attention, in terms both of depth and frequency of measurement.

A final conclusion is that both A.I.D. and Philippine national family planning program managers failed to take full advantage of key messages from those data that *did* reach them, for example, from service statistics and surveys of knowledge, attitudes, and practices.

8. A program that offers services must also generate demand for them. Potential clients must be aware of the existence and benefits of these services. The conclusion with respect to Outreach is that it was an exciting innovation, but demand generation received very little attention.

Currently the demand for services—sterilization rather than reversible methods—appears high, but the program can take only some of the credit for this situation. The conclusion here is that if the demand for sterilization has increased during the past decade, it is due more to changes in the cultural setting and the perceived costs of children than to economic development, which was slow in the 1980s, or to program stimuli, which diminished throughout the 1980s.

In terms of the question, "Who is most likely to use nonsupply methods?", it was concluded that for reasons of inaccessibility of modern methods, or unwillingness to use them, poorer households have turned to nonsupply methods.

9. Fertility has continued to decrease at a rate that cannot be accounted for by the methods in which A.I.D. has made its greatest investment. Related to this is the conclusion that disproportionate resources may have been devoted to supplying methods—pills, condoms, and IUDs—that apparently appealed to only a small fraction of couples.

10. At several key points during the past 20 years, A.I.D. technical staff served as a resource to the Philippine Government. However, because at times their number was not sufficient, technical staff were often not able to participate actively as peers in discussing issues and developing new program concepts and approaches. In retrospect, given the size of the A.I.D. investment in the population sector, A.I.D. should have maintained staff both in sufficient numbers and with strong professional credentials to promote more meaningful and extensive engagement in the population program.

Definition of Terms

Child Mortality Rate: The number of deaths to children from birth through 5 years of age per 1,000 live births.

Contraceptive Acceptors: Women who become (or whose husbands become) users of a contraceptive method they have not used in the months immediately before a given period of time.

Contraceptive Prevalence Rate: The percentage of married women in reproductive age groups who are (or whose husbands are) using any form of contraception.

Contraceptive Users: Women of reproductive age who are (or whose husbands are) current users of any form of contraception.

Crude Birth Rate: Annual number of births per 1,000 persons.

Crude Death Rate: Annual number of deaths per 1,000 persons.

Dependency Ratio: The ratio of those under 15 and over 65 to the working-age population, defined as persons 15 to 64 years of age.

Infant Mortality Rate:	The number of deaths to infants under 1 year of age per 1,000 live births in a 1-year period.
Married Women of Reproductive Age:	Currently married women between the ages of 15 and 44 or 15 and 49.
Maternal Mortality Rate:	The number of deaths to women from pregnancy and childbirth complications per 100,000 live births in a given year.
Singulate Mean Age at Marriage:	Average age at first marriage, adjusted for the age distribution of a population.
Total Effective Demand:	The proportion of married women of reproductive age who, at a given point in time, are protected by contraception (commonly expressed as the contraceptive prevalence rate).
Total Fertility Rate:	The average number of children who would be born alive to a woman (or group of women) during her lifetime if she were to pass through her childbearing years conforming to the age-specific fertility rates of a given year.

Total Potential Demand: The hypothetical maximum proportion of currently married women ages 15 to 44 who would be protected by contraception if all unmet needs were satisfied and continued use of contraception were maintained.

Unmet Need: Condition of those women who should, by one or more criteria, be protected by family planning practice but are not.

Glossary

A.I.D.	Agency for International Development
AVSC	Association for Voluntary Surgical Contraception
CBD	Community-Based Distribution system
CDIE	Center for Development Information and Evaluation
CPR	contraceptive prevalence rate
FAR	fixed amount reimbursement
FPOP	Family Planning Organization of the Philippines
IDA	International Development Association (World Bank)
IEC	Information, Education, and Communication
IMCCSDI	Integrated Maternal Child Care Services and Development Incorporated
IMCH	Institute of Maternal and Child Health
IMR	infant mortality rate
IPPF	International Planned Parenthood Federation
IUD	intrauterine device

L-M Scale	Lapham-Mauldin Family Planning Program Effort Scale
KAP	knowledge, attitudes, and practices
MCRA	married couples of reproductive age
MIS	management information system
NEDA	National Economic and Development Authority
NGO	nongovernmental organization
P	peso, Philippine unit of currency
PCPD	Philippine Center for Population and Development
POPCOM	Population Commission (formerly Commission on Population)
PP I	Population Planning I, first A.I.D. bilateral program
PP II	Population Planning II, second A.I.D. bilateral program
PP III	Population Planning III, third A.I.D. bilateral program
RTI	Research Triangle Institute
TFR	total fertility rate
UNFPA	United Nations Population Fund

UPPI	University of the Philippines Population Institute
USAID	A.I.D. Mission office in the Philippines
VSC	voluntary surgical contraception

Map of the Philippines

Introduction

National family planning in the Philippines started in the late 1960s, with the establishment of the Government-appointed Population Commission (POPCOM). The population program began as a clinic-based system predominantly serving an urban population, but was modified in the mid-1970s to also provide community-based outreach to rural areas, where about 70 percent of Filipinos lived. The Agency for International Development (A.I.D.) was the most important contributor to the Philippine population program, furnishing about $100 million from 1968 to 1988.

This study of the Philippine population program is the second of six country case studies being conducted by A.I.D.'s Center for Development Information and Evaluation (CDIE) to assess A.I.D.'s assistance to family planning. As with other impact assessments planned by CDIE for other sectors, there are two purposes. The first is to look at the record of A.I.D.'s performance in carrying out family planning activities. This is the concern for effectiveness, efficiency, and sustainability. The second purpose is to discover what longer term effects or impact resulted from A.I.D.'s interventions.

There are two main audiences for this Technical Report: professionals identified with the population sector per se, and individuals concerned more broadly with economic assistance programs who have a particular interest in A.I.D.'s contributions to the development of the Philippines. Like all Technical Reports, the principal use of this country study will be to serve as a resource document for the final published Assessment Report.

A four-person study team began work in the Philippines on August 12, 1991, following interviews of knowledgeable people inside and outside the Agency, and review of a large body of printed materials (most related to A.I.D.'s program). During their time in the Philippines, team members worked in Manila and traveled to Cebu and to Davao in Mindinao, in order to visit public and private sector organizations and to meet officials and specialists associated with them. Over 100 individuals were interviewed of whom approximately one-fifth had received some kind of assistance from a family planning provider.

The Country Setting

Sociocultural Background

The Philippines represents a unique blend of oriental and western cultures, partly because of the long, uninterrupted rule of Spain followed by the sustained influence of the United States. Since there was no centralized political structure or national elite at the time of the Spanish conquest, the social and cultural evolution of the Philippines has been largely—although not primarily—shaped by the colonial experience.

Filipinos are mostly of Malay origin, closely related to the peoples of southeastern Asia and Indonesia. Later cultural additions to the population included the Chinese, who constitute the second largest ethnic community, as well as immigrants from Japan, Europe, Africa, and America. Although there are seven linguistic groups, Tagalog is the major language, spoken by more than one-half of the Philippine population. In fact, the national language known as Pilipino is primarily derived from it. Most high school graduates acquire a working knowledge of English, a required subject in the Philippines.

Over 90 percent of Filipinos are Christian, of whom about 85 percent are Roman Catholic. Muslims, located mostly in Mindinao and Sulu, constitute about 5 percent of the population.

Named for King Philip II by Spanish explorer Ferdinand Magellan in 1521, the Philippines is the 14th largest country in the world in population. Results of the 1990 census (Government of the Philippines 1991) show that the population is now 60.7 million, with an annual growth rate of 2.3 percent. It has been estimated that the total fertility rate (TFR) had declined from 5.72 in the late 1960s to about 4 births by 1990.

The Philippines has the highest literacy rates (84 percent for men and 83 percent for women) among all developing countries, including those of Asia. It also has very high enrollment rates in both the primary and secondary schools for both boys and girls. Enrollment at the tertiary level is also quite high and, because of its close relationship with the United States, many Filipinos graduate from U.S. universities.

Philippine women enjoy considerable freedom and occupy leadership positions in the public and private sectors. Many are prominent in the professions. Their labor force participation rate is 45.8 percent, compared with 82.5 percent for men.

There has been a distinct trend toward urban migration. The proportion of the population living in urban areas rose from 27 percent in 1948 to 41.6 percent in 1988. Further, it is estimated that by 1990, 26 million Filipinos had become urban residents.

Since 1980, the number of Filipinos going abroad in search of employment has increased, from 214,590 in 1975 to nearly 523,000 in 1989, with an increasing percentage of women emigrating.

The dual trends of growing emigration and urban migration, together with the country's long association with the United States, and its contacts with Canada, Australia, and other western cultures, have exposed the Philippine people to new ideas and lifestyles and have raised social and economic expectations. One consequence of these modernizing influences has been the creation of a favorable environment for family planning.

The Economic Scene

Economically, the Philippines has fallen behind its neighbors, although it started out at independence in a more advantaged position. The growth in per capita income during the past three decades has often been disappointing. In the 1960s, per capita income increased at only 2 percent per annum, rising to 3.4 percent in the 1970s and actually declining in the mid-1980s in face of the country's worsening economic situation.

Macroeconomic policies emphasizing import substitution, bias toward capital-intensive industries, neglect of agriculture, unequal distribution of assets, and overregulation of the economy have contributed to low rates of growth. Since coming to power in 1986, the Aquino Government has attempted to loosen import restrictions, dismantle agricultural monopolies, and privatize state-owned corporations. It has emphasized growth of the private sector, especially small- and medium-size enterprises, and investment in nonmetropolitan areas. However, these policies have not yet made a major difference in the economic situation of most Filipino families, with the poorest 50 percent sharing only 20 percent of all

national income, whereas 20 percent of the most affluent receive 52 percent of income.

Agricultural land is also unevenly distributed. While large landed estates have largely disappeared, most of the cultivated land is still owned by a relatively small segment of the population.

High population growth in the 1960s and 1970s produced an average annual rate of labor-force growth of 4.5 percent between 1980 and 1987. Between 1983 and 1986, urban unemployment reached 18 percent of the labor force, with wages declining about 7 percent in real terms. Each year, 750,000 new members are added to the labor force, faster than the economy can employ them.

The rapid growth of the working-age population and the inability of the economy to generate productive employment are reflected in an approximate doubling of the overall unemployment rate, which rose from 4 percent in 1975 to 8.6 percent in 1989. When underemployment is taken into account, the picture is bleaker still.

These factors form the backdrop of poverty. According to World Bank (1988) estimates for 1985, 58 percent of Philippine families had incomes below the poverty line of $256 per month. The proportion of the poor has remained constant since 1971, but almost 14 million more people have joined their ranks due to population increases. Nevertheless, as later discussion will reinforce, the effects of widespread poverty have probably been an incentive to limit family size.

The Political Situation

At the end of the second World War, when the Philippines achieved its independence, it adopted a Constitution patterned after the United States', held public elections, and established a presidential form of government. This democratic system survived until 1972, when President Marcos—realizing he could not be elected a third time—declared martial law, establishing "constitutional authoritarianism." By the mid-1980s, the worsening economic situation and excesses of authoritarian rule had led to widespread popular discontent, and a "people's power" movement swept Corazon Aquino into office. She restored individual rights and democratic institutions.

The transition to democracy has not been smooth. The Aquino Government has had to struggle to consolidate its power and authority. The coalition of disparate political groups, with competing and even conflicting ideological predilections, which had supported Corazon Aquino's quest for the presidency, has failed to grow into a united political party with a well-defined philosophy and agenda. Disgruntled elements in the military have attempted several coups, which, though unsuccessful, have demonstrated to the people the fragility of existing democratic institutions. The Government has often given the impression of being paralyzed by vested interests and has not always acted decisively to tackle the country's massive problems. The situation seems to improve only slowly and gradually.

Two political factors have constrained the family planning program. The first is a lack of sustained political commitment to the program; political leaders have seen family planning more as a liability than an asset in elections. (Perhaps it is not surprising that the authoritarian rule of the 1970s openly supported a coherent program to reduce fertility.) During its early years, the Aquino Government neglected the program and has only recently provided halfhearted support to it. Second, the powerful Catholic Church hierarchy (see Appendix A), with direct access to the highest echelons of the Government, is firmly opposed to modern contraceptive methods and publicly condemns their use. The Church's opposition has been a significant factor, thwarting the program at several junctures.

Health and Welfare Indicators

During the 1970s, some welfare indicators improved substantially, probably in correlation with the high overall growth of the period. Crude death rates dropped from 11.6 to 8.4 per 1,000, and households with safe water supplies increased from 23 to 43 percent during the decade. Infant mortality was 62 per 1,000 in 1971, but is estimated by the Population Institute of the University of the Philippines (UPPI 1990) to have improved only slightly to 60 per 1,000 in the mid-1980s. During the 1970s and 1980s, life expectancy rose, but not dramatically. For males, the increase was from about 58 years to about 60 years; for females, it rose from about 63 to about 66 years. The life expectancy figures and the infant mortality rate (IMR) are typical for the region, but progress has been relatively slow and the possibility of a sustained reversal in infant mortality is a matter of concern.

There are important variations in health and welfare indicators across geographical regions, income groups, and population subgroups. In general, rural dwellers have poorer nutrition and lower health status, and the urban poor are often worse off than the rural poor in access to housing, food, and health services.

The World Bank (1991) points out a number of conditions that place Philippine women and their children at particular risk during pregnancy and childbirth. One problem lies in intrafamily inequities in food availability, with males faring better than females. Comparatively low health standards among Philippine women—including prevalence of anemia—appear to be linked to this practice. Maternal mortality is estimated in the range of 80 to 90 per 100,000 live births, mainly from hemorrhage (38 percent) and hypertensive complications of pregnancy (28 percent). Maternal illnesses, such as anemia and undernutrition, affect almost one-half of all pregnant women, and these conditions are associated in turn with fetal loss.

Malnutrition among women, together with closely spaced births, contributes to the relatively high proportion of babies (18 percent) born with low birth weight and to the nation's infant mortality rate. The prevalence of wasting among children ages 12 to 23 months is estimated at 14 percent, while the prevalence of stunting among 2 to 5 year olds is 42 percent. UNICEF estimates (World Bank 1991) that, overall, malnutrition in Philippine children under the age of 5 is among the highest in Asia.

The Philippine Family Planning Program

Background

During the 1960s in the Philippines, as in many Asian countries, there was sudden recognition of the socioeconomic consequences of rapid population growth among a number of highly placed policymakers. Earlier, for health-related reasons rather than for fertility regulation, outstanding medical leaders, under the auspices of indigenous nongovernment organizations (NGOs) (see Appendix B), had been providing contraceptive information and services. Fiscal support for these NGO efforts and later for programs by the Government of the Philippines was sought from the international donor community, chiefly A.I.D. The box following displays a timeline of key events in the history of family planning in the Philippines. From 1968 to 1988, this partnership of the Government, NGOs, and donors worked to reduce population growth rates and to improve maternal and child health. The relative priority given to these two mutually reinforcing goals has come full circle, with health again being the central focus of the Philippine family planning program.

Policy Development

In the late 1960s and early 1970s, the Government endorsed population planning through several significant policy actions. In 1968, the Government signed the Declaration of Population by World Leaders and set up the Office of Maternal and Child Health in the Department of Health (earlier the Ministry of Health) to begin family planning activities. In 1969, President Marcos appointed POPCOM to prepare a national policy. In 1970, POPCOM was given permanent status in the Office of the President and the mandate and staff to coordinate population programming in both the public and private (mostly NGOs) sectors. The POPCOM policy had demographic targets, confirmed legislatively, which became part of the 1973 Constitution.

During the 1970s, the Philippine program expanded step by step by presidential decree to encompass all methods of family planning except abortion, which was illegal. In addition, income tax and labor laws were amended to encourage small families. Applicants for marriage licenses were required to undergo family

Historical Record of Family Planning in the Philippines
Key Events

1950s	Family Relations centers opened initially in Manila and soon thereafter nationwide.
1964	University of the Philippines Population Institute (UPPI) established.
1965	Family Relations centers reorganized as Planned Parenthood of the Philippines.
1965	Family Planning Association of the Philippines founded by a Catholic group; later (1969) merged with Planned Parenthood of the Philippines to become the Family Planning Organization of the Philippines (FPOP).
1967	The Philippines signed United Nations Declaration on Population.
1967	A.I.D. funded Institute of Maternal Child Health (IMCH) to initiate family planning training.
1968	Project office for family planning services created in Maternal/Child Health section of Ministry of Health (later the Ministry became the Department of Health).
1969	President Marcos created a 23-member commission, including Catholic Church representatives, to make recommendations about population. Based on the commission's report, the president decreed that the Population Commission (POPCOM) coordinate, plan, and make population policy.
1970	Philippine National Population Program launched at static clinics to reduce fertility.
1970	Major A.I.D. family planning project begun.
1972	Voluntary surgical contraception approved.
1972	Population education started in school system under Department of Education.
1973	Government's role in fertility reduction mandated in Philippine Constitution.
1973	Nationwide survey, as analyzed by John Laing (UPPI 1974), indicated that the family planning program, conducted through static clinics, largely limited acceptors to within a 3-kilometer radius, thereby leaving rural areas largely uncovered.
1974	Trained nurses and midwives authorized to insert intrauterine devices (IUDs) after having been authorized to prescribe pills.
1976	Outreach program launched nationwide to increase contraceptive coverage, especially in rural areas, and to involve local government units.
1977	Second A.I.D. bilateral family planning project begun.

Historical Record of Family Planning in the Philippines
Key Events (cont.)

1978	President Marcos accepted recommendations of the Special Committee to Review the Philippine Population Program, the most important of which revised the principal goal from reduction of fertility to overall welfare of the family and society.
1980	Third A.I.D. bilateral family planning project begun.
1981	National Economic and Development Authority (NEDA) eliminated demographic targets from the Government's Five-Year Development Plan.
1982	POPCOM transferred from NEDA to Ministry of Social Services and Development (later Department of Social Services and Development).
1984	Demographic targets restored in Five-Year Development Plan.
1985	POPCOM Board too divided on program thrust and direction to request renewal of A.I.D. program.
1986	Change of government.
1986	Demographic targets removed again from Five-Year Development Plan.
1987	New Constitution mandated each couple's right to make fertility decisions.
1987	New population policy issued by POPCOM Board based on family welfare and choice rather than on fertility reduction goals.
1988	POPCOM Board designated Department of Health as lead agency for family planning, with population and development issues reserved for POPCOM.
1989	NEDA Board issued new guidelines to strengthen collaboration between the Philippine Government and nongovernment organizations (NGOs); the guidelines included tax exemptions and cancellation of requirements for prior Government approval of NGO proposal for donor support.
1989	Five-Year Directional Population Plan issued.
1991	POPCOM transferred to NEDA. Chairman of the NEDA Board is the President of the Philippines.

planning counseling by a POPCOM-approved counselor. In 1974, the number of paid maternity leaves was reduced to four, and private companies with more than 200 employees were required to provide on-site family planning. In 1976, the Government modified the Philippine Medicare Law to allow Medicare reimbursements to participating physicians and institutions for voluntary sterilizations.

This was expected to qualify about 15 percent of the estimated 5.4 million married couples of reproductive age for this service. The new provisions contributed to the subsequent increase in the number of female sterilizations.

A new approach to family planning, called Outreach, began in 1976 to replace the largely clinic-based program that had grown up in the preceding years, but which was yielding diminishing returns. As the Outreach program expanded, the popularity of voluntary surgical contraception (VSC) motivated leaders of the Catholic Church to express their opposition. In 1978, President Marcos accepted the Report of the Special Committee to Review the Philippine Population Program, which recommended that the program shift its emphasis from fertility reduction to family welfare. In 1981, the National Economic and Development Authority (NEDA) eliminated fertility-reduction targets from the Government's Five-Year Development Plan.

With the change of government in 1986, individuals favoring a Philippine population program were attacked in the media, by the hierarchy of the Catholic Church, and in the Philippine Congress. A new national population policy moved the country farther away from fertility-reduction goals, stressing family welfare and maternal and child health. The Department of Health replaced POPCOM as lead agency for family planning.

In April 1988, POPCOM issued the Philippine Population Program Medium Term Plan (1989-1993). Among the nine major principles set forth in this plan, the following appear:

- Orientation toward overall improvement of the family, not just fertility reduction
- Respect for the rights of couples to determine the size of their families and to choose voluntarily the means which conform to their moral convictions and religious beliefs
- Promotion of family solidarity and responsible parenthood
- Rejection of abortion as a means for controlling fertility

Despite official opposition by much of the Catholic Church leadership to modern family planning methods, President Aquino, without endorsing contraceptives, supported the provision of the 1987 Constitution that married couples enjoy the right to make fertility decisions. The Government's 1987-1992 Development Plan calls for a population growth rate aligned with replacement fertility by the year 2010.

Program Implementation

Leadership and major implementation activities of the family planning program were vested in POPCOM from 1973 to 1988. In 1976, POPCOM began the Outreach Program to extend its services to underserved, largely rural areas. Aside from China, this was the largest single community-based distribution effort ever undertaken to bring contraceptive information and supplies to villagers. Outreach established a supply point in each of the 52,000 *barangays* (villages; smallest unit of government) with a volunteer worker to motivate and resupply barangay residents. The barangay volunteers were supervised by 3,000 full-time Outreach workers, who recruited and referred patients and prescribed pills and other nonsurgical methods. Highly dedicated and hardworking, these workers received only a few weeks of training, a shortfall that compounded two weaknesses of the Philippine program: a very high dropout rate and the growing use of less effective contraceptive methods (i.e., rhythm, condoms, and withdrawal). In addition, Outreach was an administrative enigma. While workers were officially part of the staff of the local government unit, and it was intended that their salaries would be gradually assumed by the local units, they were recruited, trained, and initially paid by POPCOM. Although working in the health field, Outreach workers were delinked from the Department of Health and were often resented by Health Department staff.

As Outreach workers steadily increased their role, the Department of Health gradually reduced its commitment to family planning. This waning commitment is reflected in the declining number of patients served in Health Department clinics—from 336,577 acceptors in 1973 to 179,603 in 1984 at the height of Outreach—a reduction of nearly one-half—as well as in the reduction in the number of top-level Department of Health staff working in family planning, from 150 in 1976 to 50 in 1989. This decline in patients served had serious implications for the use of the more effective methods, since it was only from Health Department clinics that acceptors could receive an intrauterine device (IUD), the least costly but among the most use-effective methods.

Despite its shortcomings, Outreach was the major actor in the Philippine program. Philippine and A.I.D. officials saw it as a means of securing nationwide awareness of and commitment to family planning, and it achieved this goal to a remarkable degree.

A.I.D. Assistance

Background

CDIE's field study of the Philippines examined family planning activities carried out during the 1968-1988 period. With the exception of the Agency's early support to the private sector in the late 1960s, before the Government began its national program, A.I.D. worked throughout that period within the framework established by the Government. Certain of its representatives, including Mission Directors, deputy Mission directors, health and population officers and their colleagues, population specialists from A.I.D./Washington, as well as personnel attached to Mission and A.I.D. contractor organizations, initiated and maintained dialogues with host country counterparts and representatives of other donors, and worked closely with the Government in conceptualizing, planning, and executing its successive family planning activities.

Conversations with senior Government officials and NGO representatives (most of whom had been engaged in some part of the Philippine family planning program for the full 20-year period) led evaluation team members to conclude that the advice and counsel—especially the technical guidance supplied by U.S. population specialists—were valued throughout the period, and particular expertise was requested at especially critical points.

Perhaps the uniformly positive feeling about A.I.D.'s role is best understood when it is noted that almost from the beginning, A.I.D.'s program was the Philippine program. *A major conclusion is that over the 20-year period, A.I.D. accomplished an identification with the Government family planning efforts so close that the Agency's activities and those of the national program were virtually indistinguishable.* One of the most senior officials of the Government referred to this close association by saying, "When POPCOM zigged, A.I.D. zigged, and when POPCOM zagged, A.I.D. zagged."

The historical record bears this out. After the Philippine program began in 1970, A.I.D. came in with its first bilateral project, Population Planning I (PP I), in 1971. When the Government, convinced that the clinic-based program was not reaching a wide enough portion of the target group, launched Outreach in 1976, A.I.D. responded the following year with its second bilateral project, Population Planning II (PP II), which served as the major funding for Outreach. And despite some of the problems identified with Outreach, when funding for continuation of

the program ran down, A.I.D. approved a third bilateral project, Population Planning III (PP III), the largest up to that point.

The record shows that in addition to the constructive professional relationships that developed between A.I.D. representatives and Philippine family planning program personnel, A.I.D. furnished about $100 million in obligated funds from 1968 to 1988.

As later sections of this report will demonstrate, the financial support provided by A.I.D. was *critical* to the initiation and continuation, over two decades, of the Philippine family planning program. A.I.D. contributed 58 percent of *total* family planning expenditures during the very important first 5 years, when family planning was gaining a foothold in the Philippines. Of all external contributions, A.I.D.'s share was 74 percent during this period. Between 1970 and 1988, when external agencies accounted for nearly 57 percent of total program expenditures, A.I.D. was providing two-thirds of that amount. This partnership enables A.I.D. to associate itself with the accomplishments of that effort; and there have been many, as this report will show. However, it also ties A.I.D. to whatever problems, shortcomings, and failures the effort produced. *When a donor gets as closely involved with a host country effort as A.I.D. has been with the Philippine national family planning program, it shares both the credit and criticism for what transpired.*

Looking at A.I.D.'s population efforts in the Philippines, one must consider the varying elements that affected the interaction of supply and demand from 1968 to 1988, as the Government moved from a clinic-based system in the Department of Health to an all-powerful, albeit inadequately funded, quasi-independent commission (POPCOM), and then back to a Health Department system. These dramatic shifts in program focus and implementation strategies reflected changes in commitment of national leadership to family planning. Despite the rhetoric of the early years, the national leadership never provided adequate funds for staff salaries, training, equipment, or contraceptive supplies. More important, no *consistent* commitment in the Philippine Congress or at the local government level was demonstrated.

Several years after the initiation of the program, it became apparent that the Department of Health lacked the capacity to deliver health or family planning services to the majority of the people. POPCOM responded by testing the precursor of the Outreach Program in seven regions for about a year. Before the data from the pilot studies were fully analyzed, POPCOM went nationwide in

1976 with program implementation of Outreach. Unfortunately, it never attracted fully adequate funding from the local government units or the national Government, and by 1985, the Philippine Population Program as embodied by POPCOM had lost most of its political support and its administrative capability. By 1988, the family planning aspect of the program had reverted to the Department of Health, now significantly stronger in its delivery and administrative capacity than in 1968, but still untested in a program as complex as family planning.

Population Planning I, 1970-1976

By 1967, before the Government had a national family planning program, A.I.D. was providing direct and indirect (through centrally funded grantees and contractors) support to Philippine universities and NGOs concerned with population matters. There is no evidence that a longer term Mission population strategy was in place nor that A.I.D.'s early assistance was more than an ad hoc response to "targets of opportunity."

In 1970, POPCOM launched the Philippine National Population Program to reduce the rate of population growth. To support this initiative, A.I.D. undertook its first family planning project, PP I, funded in 1970 for $11 million. During the 6-year period of PP I, A.I.D. provided funds to train staff for Department of Health and NGO clinics and supported the establishment and equipping of 2,400 family planning service units, 11 POPCOM regional offices, 35 hospital-based VSC units, and 456 VSC units in nonhospital settings. With the launching of Outreach in 1976, PP I funds helped train 513 district population officers, 3,103 full-time Outreach workers, and 77 trainers.

At midpoint in the project, an A.I.D.-supported analysis (Laing and Philipps 1974) of a national demographic survey showed that whereas 70 percent of the population lived in rural areas, nearly all clinics were located in the towns. Within 3 kilometers of these clinics, roughly one-third of eligible couples were regular users of contraceptives. Prevalence declined sharply, however, for potential acceptors who were farther removed—to as little as 5 percent among those living 10 kilometers away. The fact that easy-to-reach acceptors had been served accounted in large measure for the "plateauing effect" of the program's first 3 years. A major conclusion of this watershed study was that the clinic-based strategy did not reach the majority of the target group of married couples of reproductive age. It led to the founding of Outreach.

Despite substantial accomplishments, a major finding of a 1976 Inspector General's report was that the A.I.D.-supported family planning program had "serious current problems," including POPCOM's lack of standardized written policies, procedures, and practices (in one clinic acceptors were told to wash out condoms and reuse them); a universal shortage of information, education, and communication (IEC) materials, some of which were written in the wrong dialect; and failure of the management information system (MIS) to actually generate management-oriented information (e.g., the system was producing summary reports showing "new acceptors," without reporting data on dropouts).

Population Planning II, 1977-1980

In 1976, the Government elaborated a new goal to reduce the population growth rate by 1 percent annually during the life of the project. Achievement of this ambitious goal would have required improvement in the contraceptive prevalence rate from 24 percent in 1977 to 35 percent by the end of 1980, or about 2.5 percentage points per year. (In comparison, Taiwan and Korea, with highly successful programs, had not been able to rise above 2 points per year.)

A.I.D. provided grant assistance in the amount of almost $14 million, with the Government contributing about $16 million. The project was the major funding for Outreach, which received 75 percent of project funds. Major emphases were VSC, establishment of a logistics system which reached the 52,000 barangay supply points, and an IEC system to support full-time Outreach workers. The logistics system was particularly notable because of its outstanding success. PP II also included a demographic measurement subcontract.

At the end of PP II, a significant share of the recurrent costs of Outreach were to be absorbed at the local level through signed agreements. The 1978 program evaluation (Government of the Philippines) found fairly high political support at all levels of the local government units, but noted a general view among central policymakers that Outreach might not be financially viable as designed for the long run. This skeptical view reflected opinions of many POPCOM Board members. Thus, when Outreach was less than 2 years old, it was being judged by key Filipinos as fiscally unsustainable. Further, the evaluation pointed to a poorly functioning MIS system throughout the country and noted that full-time Outreach workers complained that only 25 percent of their 21-day training related to family planning skills.

Population Planning III, 1980-1986

Two years after the 1978 evaluation, an A.I.D. audit (USAID/Manila 1980a) reiterated many of the earlier cited problems, including—once more—a weak and unreliable MIS. A.I.D.'s 1980 Project Paper for PP III suggested, however, that Outreach was achieving its goals, at least in rural areas, for example, the CPR in 1978 was higher (46 percent) in Outreach areas than in the country as a whole. More important, the rate of contraceptive use among less-educated women (those most likely to live in Outreach areas) rose more rapidly than among better educated women.

An impact assessment of 1981 (Herrin and Pullum) also reported some encouraging, although mixed, findings. Prevalence of more effective methods had increased slowly but steadily to 14 percent by 1980. (In comparison, use of the more effective methods in Thailand in 1979 was 49.2 percent.) At the same time, the prevalence rate of less effective methods also increased in the Philippines, reaching 28 percent by 1980. However, there was hopeful news in Outreach areas; the less-effective methods declined by almost 4 percent between 1978 and 1980, while use of more effective methods increased by approximately the same percentage. Moreover, women in Outreach areas who wanted no more children turned in significant numbers to the more effective methods, mostly to VSC, which increased from 4.9 to 14.4 percent of prevalence by 1980. Multivariate analysis of the 1980 data suggested that Outreach had significantly impacted on prevalence.

The 1981 process evaluation, conducted by 10 persons representing A.I.D., POPCOM, and NEDA produced the following key findings:

- Overall program coordination had improved substantially since 1978. Outreach was proving to be a workable approach and significant improvements in management had been made since 1978.
- National funding was adequate, but local government units were picking up only 30 percent of total Outreach expenditures, thereby indicating that the capacity of these units to support Outreach costs had not been fully explored at the time PP II was designed. On average, local government units were by 1980 contributing 80 percent of the amount they had pledged.

- Despite the generally adequate levels of funding for the project, there were liquidity problems, due in part to A.I.D.'s installation in 1978 of the fixed amount reimbursement (FAR) system. POPCOM and local government personnel did not understand the role of financial reporting under FAR, and their tardiness in providing necessary reports delayed A.I.D. reimbursement of funds to POPCOM. This in turn slowed disbursement to the lowest levels, thereby affecting both the rate and quality of program implementation. An important effect was that delayed reimbursement to physicians who performed sterilizations contributed to a slackening in the rate of growth for this method, despite reportedly high demand. The delays lowered physician motivation and restricted the ability of clinics to purchase medicines and other supplies.
- Outreach workers' understanding of contraceptive technology was inadequate. Barangay officers were even less well trained. For example, nearly two-thirds of the officers believed that condoms were more effective than IUDs.
- On average, Outreach workers dispensed only 4.2 cycles of pills and 27 condoms per month, but these low figures were balanced by the fact that the Outreach system supplied overall more than 30 percent of the nonsurgical contraceptives.
- Very few Outreach workers had promotional materials.
- Of the effective methods, only acceptance of VSC had increased over the past 5 years.
- Operations research was amply funded, but little money was expended, particularly to answer key questions which could not be probed by large-scale surveys. POPCOM's unwillingness to utilize research funds is surprising in view of the consternation expressed by POPCOM leaders concerning the continuing low rate of effective contraceptive choice.

These findings, although not overwhelmingly positive, were encouraging enough for A.I.D. to provide further support to Outreach through PP III, a 5-year project of approximately $30 million in grant funds and $27 million in loaned

monies. It was estimated the Government's share would reach almost $66 million.

The sector goal of the new project was to reduce population growth from 2.3 percent in 1980 to an estimated 2 percent in 1985. The project purpose was to raise the CPR from 43 percent in 1980 to 53 percent in 1985, while increasing overall contraceptive use-effectiveness (defined as the percentage of reduction in fertility among reported users of contraceptives of all types).

The new project provided funds for recurrent salaries, training, and travel expenses for 3,000 full-time Outreach workers and 600 population managers, plus training for 42,000 barangay supply point officers. In addition, support was made available to upgrade Department of Health regional centers and staff, continue reimbursement of clinic costs of VSC, intensify IEC efforts, and provide $1.5 million for innovative activities in the private and public sectors. Money was included for operations research and to increase the quantity of data and its more timely analysis, as well as for an improved MIS. Of particular importance was the Government's and the Mission's recognition that "...the high costs of the Outreach project and cost-effectiveness [have] become [major issues] in the Philippine Population Program" (USAID/Manila 1980b). It was noted that after PP III, A.I.D. would no longer provide financial support for the recurrent costs of Outreach workers' salaries and travel. The Government had already said it would make changes given the high cost of maintenance. Against this backdrop, support was budgeted to test various schemes for cost-effective service delivery.

In addition to cost-effectiveness, the Project Paper (USAID/Manila 1980b) addressed the following concerns:

- *Use of less effective contraceptive methods.* The projected CPR in 1980 was 43 percent. However, only 15 percent of married couples of reproductive age, or about one-third of contraceptive users, were estimated to be using the most effective methods (pills, IUDs, and sterilization). Thus, roughly two-thirds of those using a means of fertility control were using condoms and other traditional methods, or some combination thereof. As a counterweight, substantial funding was included for sterilization and IUD use.
- *Financial viability.* PP II had envisaged that local governments would meet 100 percent of Outreach program costs by 1980. This had proven unrealistic, and the new project recognized that

the local and national governments would have to share responsibility, with POPCOM charged with monitoring local government contributions more closely.

- *Financial management.* In 1978, when the FAR system was applied, Outreach was beset by serious liquidity problems. There were delays in payments of salaries of field staff, subsidies for voluntary sterilization, and major activity costs, such as IEC and training. These difficulties were eased in 1980 when the Ministry of Budget began advancing funds for the POPCOM and A.I.D. contributions. However, the financial reporting system needed revision to shorten the 4-month turnaround period. A task force composed of Mission, POPCOM, and Ministry of Budget people suggested ways to eliminate some of the problems. The Project Paper (USAID/Manila 1980b) stated that "...the financial system will remain under close monitoring and study to determine whether it is functioning adequately."

PP III was designed and funded during a period of enthusiasm, especially at the field level, but project implementation occurred under increasingly unstable political conditions. Support from the top became rare. The program's failure to reach unrealistic, self-imposed targets cost it some support and diminished its reputation, a factor that deserves particular attention, since a key element in the sustainability of a program is the appearance of success it gives to observers. Perhaps fearful of more negative findings, POPCOM canceled the 1982 fertility survey, postponed the 1985 fertility survey for a year, and never released the final report of the 1983 survey. Likewise, the 1982 joint POPCOM-USAID evaluation was not conducted, and the 1985 evaluation was postponed for a year. Equally serious, no models for a more cost-effective Outreach program were designed or tested, and only limited operations research was undertaken.

The 1986 evaluation (Pullum et al.) found all the failures listed in the 1981 evaluation plus a few more:

- Despite efforts to correct the MIS, it was still not functioning well enough to guide policy and management decisions.
- Desired family size, in excess of four children, remained high.
- Despite a highly educated populace, there had been no significant increase in the use of modern contraceptives.

- POPCOM had reduced headquarters staff by 91 positions, and USAID staff had also declined to the point where it had no time to provide technical guidance or to visit the field. In the days of PP II and the early years of PP III, the Mission had a large population staff actively engaged in many aspects of program management. Subsequently, the staff was much reduced in size and less involved in day-to-day operations. Personnel reductions resulted in the staff focusing almost exclusively on formal project administration, which too often had the negative connotation of rule enforcement. The old informal collegial relationship was replaced by formal exchanges between POPCOM and USAID. Perhaps the most marked result of this change in atmosphere was the successive failure by POPCOM beginning in 1985 to present a proposal to A.I.D. for a follow-on project.
- NGOs were very active but not well coordinated.
- The commercial sector, although serving as much as one-third of all pill users, was completely outside the national program.
- Even in areas of special emphasis, POPCOM did not reach its targeted outputs, for example, of 840 VSC centers, only 493 were active.

Shortly after completing the 1986 evaluation, the Marcos Government was replaced by the Aquino Government. Because of the new Government's close ties to the Catholic Church and a weakening of POPCOM's authority, the family planning policy and service delivery programs came to a virtual standstill.

Interim Period, 1986-1990

During the "dormant" period from 1986-1990, USAID was able to keep a number of key NGOs functioning and to encourage the emergence of other institutions, largely through the use of "creative funding." The Government subsequently endorsed these new organizations, supporting their role in the revitalized family planning program.

With the official termination of the bilateral family planning program in 1988, A.I.D. utilized unexpended funds for the following purposes:

- Six million dollars were put in the Child Survival Program to add a stronger family planning component and strengthen the operational capacity of the Department of Health.
- Two and one-half million dollars were provided to the U.S. Bureau of the Census to assist the National Statistics Office in preparing, implementing, and analyzing the 1990 Census on Population and Housing.
- One and one-half million dollars were reserved for operation program grants. The Asia Foundation received $762,000 to strengthen NGO family planning activities, but the Foundation's more important work was to assist the new Philippine Population and Health Council of the NGOs. This council had developed to the point where it could speak with a strong voice to legislative and other key groups on the importance of family planning to health and national development. Under the Family Planning Organization of the Philippines (FPOP), with technical assistance from the John Snow Research and Training Institute, the council will direct funds to the NGO family and, to a degree, manage grants.
- The second largest grant, $650,000, went to FPOP to increase services, especially VSC, which, as shown in Table 1, FPOP was able to do. FPOP also took a pioneering role in reaching out to high-risk mothers. FPOP service statistics indicated that by 1990, 1,761 or 4.1 percent of acceptors were under age 19; 4,177 or 9.8 percent of acceptors were over age 36; 11,410 or 26.7 percent of acceptors had four or more children; and the youngest child of 22,619 or 52.9 percent of acceptors was below 2 years of age (percentages not mutually exclusive).
- A smaller grant of $88,000 supported the Youth Center Project of the Philippine Center for Population and Development.

USAID/Philippines also used centrally funded contracts to continue activities. Among the major efforts: Association for Voluntary Surgical Contraception (AVSC) provided much needed support for VSC, the Population Council completed the successful field testing of the new implant, Norplant; John Snow, Inc. provided imaginative leadership in testing a variety of workplace family planning models, and the Futures Group began lengthy discussions about the acceptability

of advertising with the commercial sector and provided technical assistance to POPCOM for POPCOM's new initiatives in policy development dialogues.

Table 1. Family Planning Organization of the Philippines Number of New Acceptors, All Methods

Year	Method							Total
	Oral	IUD	Injectable	Condom	Spermicide	Natural Family Planning	VSC	
1988	30,349	3,837	3,953	5,830	1,507	2,661	5,197	53,334
1989	41,164	3,767	2,242	3,835	1,722	2,587	2,662	57,979
1990	47,631	3,795	875	6,566	2,204	3,464	13,258	77,793

Source: FPOP (1990).

Note: VSC = voluntary surgical contraception, FPOP = Family Planning Organization of the Philippines. VSC statictics for males and females are combined and are listed with other new acceptors in FPOP records. VSC dropped in 1989 before FPOP secured independent funds for clinic costs, but increased dramatically when nongovernment funds were obtained. The number of injectable acceptors dropped in 1990 after injectables were removed from the import list.

Program Performance

A major purpose of the Philippines field study was to examine the record of performance in carrying out family planning activities, responding to concern for effectiveness, efficiency, and sustainability.

Effectiveness

The field study examined program effectiveness to assess whether the target group of married couples of reproductive age were using family planning services, technical packages, or other products; whether there was equity or bias in access; and whether coverage of the target group was as planned.

The Lapham-Mauldin Scale

The study used the 30-item Lapham-Mauldin Family Planning Program Effort Scale (L-M Scale), discussed in Appendix C, to reach conclusions concerning effectiveness. Program effort is defined as "the sum of the policies adopted and implemented; the activities carried out to provide family planning knowledge, supplies, and services; the availability and accessibility of fertility regulation methods; and the monitoring and evaluation of all of these." The team used a version of the L-M Scale that has four components: (1) policy and stage-setting activities; (2) service and service-related activities; (3) record keeping and evaluation; and (4) availability. The score range for each scale item is 0 to 4, with four indicating a strong policy or much activity on an item.

The underlying principle of the L-M Scale is that a family planning program need not score high on every item to demonstrate successful program effort. In fact, programs considered strong have sometimes been unable to score at all on some items. Rather, an effective program is one that scores well across the several categories. Moreover, a score of four does not mean that the country is achieving the maximum results possible. A score of four on the training item, for example, can be obtained by having "very good" answers on training for two categories of personnel and "moderately good" on training for four other categories. Such a country might have poor or no training for a seventh category of personnel; but in any case, the four "moderately good" situations could be improved.

The 1982 and 1989 Applications of the L-M Scale

The team used three applications of the L-M Scale. The first two, based on the results of the use of the L-M Scale by "knowledgeable observers" in the Philippines, were obtained for 1982 and 1989 (see Table 2).

The record of the Philippines family planning program as reflected in program effort scores for the 1982-1989 period may be characterized at best as a plateauing of effort. At worst, there was retrogression. Comparatively, over the 1982-1989 period, only seven developing countries showed a *decrease* (greater than one point) in program effort: Brazil, Colombia, Dominican Republic, Liberia, Nicaragua, Somalia, and the Philippines. Among Asian countries with which A.I.D. has carried out family planning programs, while the Philippines dropped during that time from 66.80 to 58.14, Bangladesh improved from 68.50 to 84.10, Indonesia improved from 89.90 to 93.40, and Thailand improved from 72.90 to 93.00.

Given that the total possible score is 120, the 1989 actual total of 58 represents achievement of only 48 percent. This is down from the 1982 level of 56 percent. Lapham and Mauldin (Mauldin and Ross 1991) constructed a "Program Effort Level" scale, based on the percentage of the maximum 120 points achieved by each country. Their scale is as follows, with the Philippine 1982 and 1989 percentages listed to show that, in both years, the Philippine program could be characterized as only "moderately strong."

		Philippine Scores	
Program Effort Level	Score	1982	1989
Strong	67 +		
Moderately strong	46 - 66	56	48
Weak	21 - 45		
Very weak or none	0 - 20		

Table 2 shows that scores dropped on each of the four major sections of the L-M Scale; the largest decrease, 3.33 points, was in service and service-related activities. Availability and accessibility of contraceptives decreased from 16 in 1982 to 13.61 in 1989, while policy and stage-setting activities went from 18.20 in 1982 to 16.16 in 1989. Record keeping and evaluation showed a drop of only

Table 2. Family Planning Program Effort Scores Derived from the Lapham-Mauldin Scale for 1982 and 1989

Category and Item	Total Score Possible	1982 Scores	1989 Scores	Difference in Scores
Policy & Stage-Setting	32	18.20	16.16	-2.04
Fertility reduction policy		4.00	4.00	0.00
Leadership statements		3.00	0.00	-3.00
Level of program leadership		3.00	0.66	-2.34
Age at marriage policy		0.00	0.00	0.00
Import law and regulations		3.00	2.50	-0.50
Advertising contraceptives allowed		1.00	4.00	+3.00
Other ministry and public agencies		3.20	4.00	+0.80
In-country program budget		1.00	1.00	0.00
Service and Service-Related Activities	52	27.00	23.67	-3.33
Private sector involvement		3.50	4.00	+0.50
Use of civil bureaucracy		2.20	0.96	-1.24
Community-based distribution program		2.50	2.80	+0.30
Social marketing program		0.00	0.00	0.00
Postpartum program		0.70	0.98	+0.28
Home-visiting workers		3.30	0.88	-2.42
Administrative structure		2.00	3.00	+1.00
Training program		2.50	3.33	+0.83
Personnel carry out tasks		1.70	3.16	+1.46
Logistics and transportation		2.80	2.11	-0.69
Supervisory system		1.00	1.50	+0.50
Mass media for IEC		3.30	0.95	-2.35
Incentives and disincentives		1.50	0.00	-1.50
Record Keeping and Evaluation	12	5.60	4.70	-0.90
Record keeping		1.40	1.30	-0.10
Evaluation		2.20	1.20	-1.00
Management use of evaluation results		2.00	2.20	+0.20
Availability and Accessibility	24	16.00	13.61	-2.39
Male sterilization		2.00	0.60	-1.40
Female sterilization		2.20	3.00	+0.80
Pills		3.70	3.00	-0.70
IUDs		3.20	2.68	-0.52
Condoms		3.90	3.00	-0.90
Abortion		1.00	1.33	+0.33
Total	120	66.80	58.14	-8.66

Source: Data from the Population Council.

0.90, although, given that the maximum possible score for this section is 12, the Philippines has performed especially poorly on this part of the L-M Scale, with only 39 percent of total possible points.

Nevertheless, there were higher scores in 1989 for 12 of 30 items: contraceptive advertising, public and private sector involvement, community-based distribution, the postpartum program, administrative structure, training activities, task implementation by each category of family planning program staff, supervision, management use of evaluation results, and availability and accessibility of female sterilization and abortion (despite the fact that abortion is illegal and officially unavailable in the Philippines). There was no change for three policy and stage-setting items, that is, policy on fertility reduction remained at the highest possible score of 4 (the high mark for 1989 was perhaps the result of President Aquino's positive, although restrained, statements in support of family planning and provisions of the 1987-1992 Development Plan, which set a target of replacement fertility by the year 2010); there was no legally defined age at marriage, leading to a 0 score; and the in-country budget performance did not rise above 1. No change was recorded for social marketing; that item received a score of 0.

Of all four categories, availability and accessibility scored highest in both 1982 and 1989 (67 percent of the total possible score in 1982 and 58 percent in 1989). This factor is important, because the question of the target group's use of A.I.D.-supported family planning activities is central in the definition of "effectiveness" CDIE used for assessing family planning. As other sections of this report of the field study show, it was in fact an availability and accessibility question that catalyzed the Government and A.I.D. to change from a clinic-based system to the Outreach program. There was systematic bias in the clinic-based system and to correct it, a broader, community-based service delivery was introduced.

Use of the L-M Scale by the CDIE Evaluation Team

The team's third use of the L-M Scale was at the time of the evaluation, with conclusions very similar to those obtained in the first two applications. The team did not, however, arrive at numerical scores. (Detailed notes concerning the major components of the L-M Scale are found in Appendix C.) Its major conclusions are as follows:

- Highly visible support was forthcoming from President Marcos. While President Aquino avoided public endorsement of modern

contraceptives, her administration has supported family planning.

- From 1970 to 1988, the Government's financial contribution covered only 42 percent of population program costs.
- No effort was made to involve the commercial sector, and advertising of contraceptives was muted.
- The noncommercial private sector had been significantly involved in family planning for more than two decades.
- The civil bureaucracy was not heavily used to ensure that program directions were carried out at the central, provincial, state, or lower levels.
- The creation of Outreach was a response to the realization that its predecessor, the static, clinic-based system, was not reaching a large enough part of the target group.
- Until recently, a major failure of the program had been its total rejection of social marketing.
- POPCOM set up a parallel structure competitive with the family planning operations of the Department of Health.
- Under Outreach, field-workers were not under a unified command: POPCOM retained technical direction, but local government units had administrative control. Moreover, contraceptive supplies were provided by POPCOM, but referrals for specialist services were made to Department of Health clinics.
- The Philippines trained top-flight surgical contraception teams who were so outstanding that A.I.D. and other donors sent them to train local VSC teams in Africa and other Asian countries—an often overlooked second-generation multiplier effect.
- How many of the trained personnel remained after the 20-year period? A 1988 United Nations Population Fund (UNFPA) study of current family planning workers showed that only 40 percent of physicians and nurses and 53 percent of midwives had taken courses in family planning.

- The training had quality limitations: The major flaw was its failure to ensure that trainees comprehended the important health benefits of selecting the most effective methods. The next most serious flaw was the failure over the 20-year period to establish preservice family planning training for students of nursing, midwifery, and medicine, at least in the non-Catholic schools of medicine. Finally, management training for senior and midlevel administrators had long been neglected.
- Although the logistics system received early high marks, it began to weaken in the late 1980s with some supplies, for example IUDs, running low or being exhausted. The logistics and commodities system built by POPCOM with A.I.D. support was sustainable, if POPCOM and the Department of Health could agree on how to employ it.
- Years before the Government recognized the importance of IEC to attaining policy and program goals, the NGO community was deeply involved in promoting family planning concepts.
- The major successes of the NGO and POPCOM IEC efforts were the enunciation and spread of awareness of the concept of family planning to 97 percent of married couples of reproductive age.
- The IEC program failed in two major respects. The first was the gap between knowledge and action; those with knowledge of family planning neglected to act on it. Second, along with service providers, the IEC efforts failed to inform new acceptors of the health and economic benefits of selecting and continuing with effective contraceptive methods. These two flaws, especially the failure to inform new acceptors of contraceptive benefits, greatly contributed to the lower effectiveness of the Philippine program compared with program effectiveness in other countries of the region.
- A 1978 evaluation identified a poor MIS; a 1980 A.I.D. audit (USAID/Manila) criticized a weak and unreliable system; and a 1986 evaluation (Pullum et al.) showed that an effective MIS was still not functioning.

- A major program deficiency was the lack of regular, systematic surveillance.
- Research had received an annual 6 percent of the program budget, but more serious was the absence of a research strategy in which the need for specific answers would be the basis for new investigations. Studies that have been conducted have been variously unfocused, uncoordinated, and not brought to the attention of program managers and decision makers.
- Except for the use of 1973 National Demographic Survey results, which stimulated the creation of the Outreach program, POPCOM appears to have ignored key messages from the service statistics and knowledge, attitude, and practices (KAP) surveys.
- Voluntary female sterilization has been available at no cost since the mid-1970s, accounting in 1988 for 30 percent of prevalence. However, voluntary female sterilization has not been able to attract acceptors before they have reached an average of parity four.
- The popularity of condoms has declined due to cultural preferences and their high failure rate.
- In terms of absolute number of acceptors, pills have been the contraceptive of choice, particularly during the peak Outreach years. In recent years they have contributed to less contraceptive prevalence than VSC due to poor use-effectiveness.
- Along with high drop out rates for pill users, the most serious flaw in program implementation was the flat acceptance rate for IUDs.

Efficiency

The definition of efficiency for this CDIE family planning assessment is "the results of an intervention in relation to its costs." For many reasons, efficiency measures are hard to find in most countries. A major problem is that good models have not been developed which allow both intracountry and intercountry com-

parisons of total program performance and among components of programs. However, as noted later, CDIE will make use of the FamPlan system of models to attempt such comparisons in the current Assessment of Family Planning Programs, of which this study is one.

A second and perhaps the basic problem is that sufficient data are not systematically collected and maintained. With respect to the Philippines, it is difficult to escape the conclusion that this state of affairs exists because A.I.D. and Philippine Government decision makers did not *require* either the collection of such data or the conduct of efficiency studies despite the frequent criticism by evaluation teams—of both the Philippines national family planning program and the A.I.D. family planning projects—that such data had not been systematically collected and utilized in cost analysis.

Too often, it seems, rhetoric outpaces accomplishment. Cost-effectiveness studies were to have been undertaken in PP III in the following areas: comparing alternative family planning delivery systems, conducting market research on contraceptive sales, testing new contraceptive methods, studying effectiveness of pre-MCRA contraceptive service delivery, and assessing community participation and incentive schemes for barangay supply point officers. In an effort to make Outreach as cost-effective as possible, restructured organizational models were to be pilot tested in 1981-1983 for possible phase-in during 1984-1985. Alternatives to Outreach were to be tested in preparation for "beyond 1985" when the Government was expected to fund all recurrent costs for salaries, travel, and the sterilization subsidy. Among other topics, they were to explore the integration of social services; for example, family planning in possible combination with health and nutrition.

The Project Paper stated, "The GOP and USAID recognize the high costs of the Outreach project and cost-effectiveness has become a major issue in the Philippines Population Program." After PP III, A.I.D. would no longer provide financial support for the recurrent costs of Outreach workers' salaries and travel. The Government had already announced its intention to make changes in the project given the high cost of maintenance, and considerable project support was budgeted to test various schemes for cost-effective family planning service delivery. To address these concerns, one of the project outputs was a plan for program implementation beyond 1985, based on research results. The plan was to include a detailed description of how the national family planning program was to be implemented after 1985.

Cost-Effectiveness Studies

In meetings with representatives from the NGOs, Government, and A.I.D. Mission, the team was unable to find anyone who could point to evidence that cost-effectiveness studies were ever undertaken, with the single exception of an undergraduate thesis conducted in the mid-1970s. This study looked at the use of pills, IUDs, and condoms for cost-effectiveness and found that the IUD was the cheapest and most reliable method of contraception, a result that has been widely reported elsewhere.

Cost-Benefit Studies

Among the few studies that could be located were several cost-benefit analyses (Abiad and Picazo 1989) of industry-based programs, although these have been only recently reported. For example, average benefit-to-cost ratios from studies done on programs in medium-size Philippine companies (referred to in Abiad and Picazo 1989) were shown as 4.67, and, for larger size companies, as 2.73; that is, for every peso (P) spent by the smaller companies, the companies benefited by a factor of almost 5, and larger companies benefited by a factor of almost 3. However, it was not clear what period was covered, and other details that would have permitted some judgment about the reliability of findings were lacking.

For the period under review, the only detailed report of an industry-based family planning program, and which reinforces the potential of such programs, was the Abiad and Picazo 1989 study. Since the report's major conclusions are similar to conclusions reported in studies conducted after 1988, they are summarized here:

- Each birth averted by the family planning program meant the company saved (in benefits) an amount equal to what it would have spent for dependents' utilities, entertainment, and schooling. It also saved the company delivery costs, prenatal and postnatal medical costs, certain maternity-related expenses, as well as the opportunity cost of maternity leave benefits advanced by the company and replacement costs for female employees on maternity leave.
- Between 1971 and 1986, the total cost to businesses declined from P71,000 in 1972 to P35,600 in 1987; costs per acceptor

dropped from P240 to P24; and costs per birth averted were reduced from P1,414 to P144.

- While costs declined, benefits rose from 1972 to 1987, in both current and real terms. Increases in total benefits from family planning services resulted from the increase in births averted and from the expansion of company-provided and maternity-related benefits for each dependent during the period.
- The benefit-cost ratio was high and showed a long-term increasing trend, ranging from a low of 0.46 shortly after the program started to a high of 14.6 in 1985.
- For every P1,000 the company spent to run its family planning clinic in 1987, it saved an average of P12,000. For the entire 16-year period, total savings amounted to P6 million in current prices, or P2.7 million in constant 1978 prices.
- Net savings and the benefit-to-cost ratio as quantified in the study were considered understated because benefits did not include those for the senior staff and their dependents, whose records were held in confidence by the company. Also, certain benefits proved difficult to quantify: reduced employee turnover, improved productivity, better attendance, and possibly fewer on-the-job accidents.

The Department of Health recently authorized a cost-benefits study of the past family planning effort, which supports continued Government investment in family planning. According to this analysis, from 1969-1989, the Government family planning program prevented 3,571,515 births, at a savings of P823 per birth averted. The cost to the Government of educating a child through elementary school is P1,126 and P1,487 for secondary school. Department of Health officials concluded that these findings show that the funds saved on education alone make family planning an attractive investment for the Government. These results parallel those obtained in other countries and have strengthened the position of family planning proponents in the Philippines.

The FamPlan System

The Philippine field study was augmented with an analysis of efficiency questions utilizing the FamPlan system of models. Evaluators from the Research

Triangle Institute (RTI) gathered data in the United States and during a 2-week visit to the Philippines in March 1992. A report of this analysis provides details concerning data problems, inadequacies and assumptions, and longer-term effects of the Philippine family planning program (Tarvid, Chao, and Rice 1992). Some of the findings are summarized below.

The FamPlan system consists of four models: Impact, Cost, Effect, and Benefit. *Impact* begins with a set of initial conditions, estimates the effects of changing determinants of fertility, and produces fertility rates. The initial conditions are population size, age-specific fertility rates, contraceptive users, breastfeeding duration, and abortion counts. The changing determinants include four "proximate determinants" (abortion, marriage age, breastfeeding, and contraceptive use) plus migration and mortality.

Cost disaggregates total family planning expenditures into per acceptor and per user costs using an estimate of user-to-acceptor costs for each method. The per user and per acceptor costs are then used to estimate future family planning expenditures.

Effect compares two family planning alternatives and relates the difference in production (averted births) to the difference in cost. The comparison is between the historical situation alternative, including the family planning program, and the alternative of a hypothetical situation in which there is no family planning program.

Benefit compares two benefit streams (in terms of reduced governmental expenditures) to two family planning cost streams. The components of the streams include education, health, and other social service expenditures. From this comparison, FamPlan estimates departmental savings, total sectoral savings, family planning costs, net savings, benefit-cost ratios, and internal rate of return.

CDIE asked the RTI investigators to apply FamPlan retrospectively, beginning in 1970 and ending in 1992. The base population was drawn from the 1970 census. Results for the various model applications were not at great variance with findings gained from the CDIE team's field study. An important added contribution from the FamPlan exercise was a more complete picture of the impact of the Philippine family planning program on the health, education, and other social service sectors (e.g., orphanages), as seen in the following comparison of the "with family planning program" (WFP) and the "without family planning program" (WOFP) for selected years, including 1988 (the terminal date for the CDIE study) for all social services sectors (billion pesos).

Year	WOFP	WFP	FP expenditure	Net Cumulative Savings
1970	21.7	21.7	0.2	-0.2
1975	33.1	32.9	0.7	-2.9
1980	33.2	32.0	0.7	-2.3
1985	41.0	36.3	0.4	11.9
1988	55.1	45.5	0.4	34.9

The FamPlan analysis showed that when health, education, and other social service expenditures were aggregated and the "with family planning program" compared to the "without family planning program," annual savings exceeded family planning programs by 1978, and cumulative savings exceeded cumulative costs by 1982.

The FamPlan analysts felt that the data were adequate for financial or benefit-cost assessment. With respect to benefit-cost calculations, and discounting at three values, 5, 10 and 15 percent, the following tabulation shows that at 5 and 10 percent the benefit-cost ratio exceeds unity by 1983. At 15 percent, benefits exceed costs by 1985. By 1988, the benefit-cost ratios are nearly at 3 to 1 for 5 percent, and at 2 to 1 for 10 percent. By the year 2000, the benefit-cost ratios exceed 9, 5, and 3 to 1 respectively. The internal rate of return for 1988 is 22.7 percent; it reaches 28.6 percent by the year 1999.

In broad terms, the family planning program in the Philippines got off to a good start in the 1970s, encountering problems in the 1980s. As noted earlier,

Year	5 Percent	10 Percent	15 Percent	Internal Rate of Return
1970	0.000	0.000	0.000	0.0
1980	0.584	0.508	0.440	1.0
1983	1.226	1.000	0.812	7.1
1985	1.716	1.347	1.053	16.2
1988	2.968	2.148	1.555	22.7
1999	9.005	5.201	3.051	28.6

there is little evidence of sustained governmental commitment to the program. A survey of national budgets of the past 22 years found little explicit funding for family planning, except in the earlier years. Recent Government contributions are within the Department of Health budget.

In many situations, one might believe that a lack of official enthusiasm for family planning could be countered by a demonstration of the financial wisdom of increasing family planning efforts. Certainly, FamPlan makes that case. FamPlan shows that by 1978, reductions in total social sector expenditures exceeded family planning program costs. By 1982, the reductions had recovered all of the cumulative family planning program expenditures. Even when benefits (reductions) are discounted at 15 percent per annum, break-even is achieved by 1985. Assuming no increase in prevalence and a 10 percent discount rate, FamPlan calculated a five-to-one benefits-cost ratio by the year 2000. In fact, the Population/Development Planning and Research Project at NEDA reached the same conclusion based on "investment" analysis. In their study, a 20 per 1,000 reduction in the fertility rate would correspond to a 22 percent increase in savings per capita, a 15 percent increase in total investment per worker, and a 13 percent increase in GNP per capita by the year 2015 (Orbeta 1989).

Changes to Improve Efficiency

Despite the paucity of empirical evidence, the team has identified ways in which program efficiency could have been improved. In this regard, comparison with other Asian countries is instructive. For example, surveys have indicated that a greater percentage of Filipino than Indonesian women wanted no more children. Despite these favorable indications, the Philippine program, as recently as 1987, still had 42 percent of its clients using noneffective methods, compared with only 9 percent in Indonesia. Correcting this situation requires movement on a number of fronts, but very critical are an IEC program informed by frequent feedback from evaluation and research and from field-workers who have enough experience and knowledge that they can be alert to such problems. Seen in this light, poor method selection, plus a 50 percent drop out rate among pill users, is due in no small part to personnel training inadequacies.

As another example, certain differences in numbers and types of personnel working on family planning in the Philippines and Thailand are worth noting. Although their total populations are about the same, Thailand has utilized more than two times the number of physicians as the Philippines. On the other hand,

the Philippine program has employed three times the number of field-workers as has Thailand. Conventional wisdom says that programs with many physicians are going to be costlier. There must, however, be enough physicians proportionately to provide technical guidance and to oversee those who are supervising field-workers. Put another way, for field-workers to be effective, they must be well trained, well supervised, and well supplied. The Philippine program achieved only the third element.

Although previous evaluations have noted that great numbers of courses were provided to field-workers, there were *quality* problems. Workers themselves faulted their training for not providing sufficient knowledge of contraceptives, including the relative effectiveness of different methods. Workers were as likely to promote condoms as IUDs, and rather than being taught the health benefits of child spacing and limiting, the instructions they received almost mechanically stressed the potential health counterindications of contraceptives, particularly of pills and IUDs. The negative impression given of these two highly effective contraceptive methods contributed to the high drop out rates in the Philippines, underscoring the inefficient use of training funds.

Nevertheless, the effects of inadequate training can be partially overcome if supervision is strong and frequent. Unfortunately, in the Philippines, supervision was neither, because of the lack of technically qualified supervisors, as noted, and because it was not clear who should supervise. Field-workers fell somewhere between local government units and POPCOM authorities, whereas their logical supervisors—physicians, nurses, and midwives—were all Department of Health employees. Although acceptor access in the Philippines was quite good, with a service point for every 99 married couples of reproductive age, from a medical point of view the delivery system was seriously flawed by an inadequately supervised field staff.

Program efficiency was further weakened by the target system, which did not reward the motivator or provider for *continuing* users, but did reward them for *new* acceptors, including those "new" acceptors who changed to a less effective method such as condoms. Additionally, the IEC program, while very effective in informing couples about family planning, did not persuade the majority to use family planning, particularly modern methods. In recent years, there has been a steady growth in the use of modern methods, but this appears to be the result of couples learning by experience which methods are unreliable, rather than any change in training field-workers or an IEC campaign to promote effective methods.

Finally, the historic lack of family planning courses in health workers' schools has meant that an important opportunity for cost-effective training has been lost. The current program appears to be taking strong steps to rectify this situation; that is, family planning knowledge and skills are being integrated into the preservice curriculum at schools of nursing, midwifery, and non-Catholic medical schools. Significant savings in funds and staff time will accrue to the population program, and more important, greater numbers of medical personnel will be trained to understand and prescribe effective contraceptives.

In two other key areas, logistics and VSC, POPCOM was judged to be both effective and efficient. VSC, at a cost under $12 per procedure, was below the average world cost. However, efficiency would have been greater if Filipino acceptors had a parity well below three as in Thailand; that is, if they were to adopt VSC after the third birth.

Conclusions Concerning Efficiency

Although there were no sustained efforts to collect data and conduct cost analyses between 1968 and 1988, in recent years a few cost-effectiveness studies of industry-based family planning programs have yielded favorable results and illustrate the potential of this approach. Application of the FamPlan system of models included a comparison of expenditures in the social services under "with family planning" and "without family planning" alternatives. Results showed that by the mid-1980s, a balance between costs and benefits of the family planning program is achieved, and by the year 2000, the benefits-cost ratio is five to one, at a 10 percent discount rate. The Philippine program (1968-1988) was able to produce good results in difficult areas like logistics and VSC, but remained below acceptable efficiency standards in adequately trained personnel, supervision of field-workers, continuation rates, modern versus traditional contraceptive ratios, and in reducing the gap between knowledge and practice.

Sustainability

For the purposes of this assessment, CDIE has defined sustainability as "the recipient country's ability to continue to support the population program and to provide the same benefits provided by that program following the termination of outside support."

The development community attaches great importance to program and fiscal sustainability. In general, it is easier to reach conclusions about fiscal than programmatic sustainability. The Philippine family planning program is no exception. From its beginning, the program lacked adequate in-country resources to cover recurrent costs. Donor support, chiefly from A.I.D., provided more than 50 percent of program costs for all but 8 years of the period under study. In the early 1980s, POPCOM proposed severe measures to offset this imbalance. The two major proposals, disbanding Outreach or charging fees for contraceptive services, were rejected by the 1986 evaluation team—among others—as being ill advised at that stage of the program. It was felt that demand for contraceptives was fragile, and reducing access or charging for effective methods would only weaken it further.

Some of the most effective parts of the POPCOM program were programmatically unsustainable for two main reasons: the withdrawal of donor contributions and confusion about responsibilities. For example, logistics completely collapsed in 1988 when A.I.D. stopped providing contraceptives and after the logistics system had been only partially transferred from POPCOM to the Department of Health.

As of 1988, the high level of awareness achieved by the program remained, and demand for services appeared to be increasing, but sustainability of IEC and training (except for clinical skills) in their existing form and without major revision were out of the question.

Two approaches to evaluating sustainability were undertaken in the evaluation. Both are based on information obtained from published materials and interviews of Philippine and A.I.D. officials and presented elsewhere in this report. To attempt a more focused analysis of sustainability (as of 1988), this information was applied to two different, although related, frameworks.

Sustainability: The Nine-Component Scale

The Population Office of A.I.D. developed a nine-item scale in its March 1991 response to the Committee on Appropriations of the United States Senate (USAID 1991). While the Population Office did not present the scale as a way to evaluate sustainability, CDIE used it as such in its evaluation, with each scale component applied to the Philippine family planning program, in sustainability terms, as follows:

1. *Adequate Contraceptive Supplies.* For most of the period, supplies were abundant even at the most distant resupply points.

2. *Variety of Contraceptive Methods.* The Philippine program rated high marks until recent years, when injections were removed and when Norplant had not been brought into the program as rapidly as would have been desired following a highly successful field test.

3. *Multiple Service Delivery Channels.* NGOs were important as service providers. However, that channel largely collapsed when POPCOM's authority was diminished. Other delivery channels, such as commercial firms, social marketing, and private practitioners, were not integrated into the system. Thus, there was no fallback position when Outreach faltered in the mid-1980s.

4. *Sound Management.* POPCOM management was more enthusiastic than sound. Outreach was launched nationally without any real operations research on its fiscal sustainability or its administrative soundness. Furthermore, management appears to have ignored for the most part reports of program deficiencies in training, IEC, MIS, and operations research. Equally important, management ignored the advice of the Special Committee, which urged the program to shift to a health welfare as opposed to a demographic target basis. Finally, management seems not to have recognized the importance of technically qualified supervisors for the Outreach cadre. All of this poor management contributed to the program's lack of success and thus sustainability.

5. *Public- and Private-Sector Involvement.* Many parts of the National, regional, and local government unit levels of the Philippine Government were involved in planning and implementing the program. The NGO community played an important role. However, the commercial sector was excluded from the national program. This omission was one of the most serious flaws of the program.

6. *Strong Leadership.* The Philippine Government itself has characterized shifts in POPCOM leadership as one of the reasons the program achieved only modest success. The CDIE team found this same view among former high-level POPCOM employees. Comparatively speaking, the multiple changes in Philippine program leadership is in marked contrast to the single powerful family planning head in Indonesia and the succession of strong leaders in Thailand.

7. *Measurement and Evaluation of Program Impact.* The Philippines is blessed with world-class demographers and evaluators who reviewed program

outputs on a fairly regular basis until the mid-1980s. Sound managers could have used the findings of these experts to correct program performance. However, except for the 1973 National Demographic Survey, evaluations of the program were not used effectively. This was a very serious omission, particularly in light of the poorly functioning MIS. Ignoring evaluation findings, POPCOM continued to set unrealistically high targets, which in turn caused the program to be perceived as a failure or, at best, a program of limited success.

8. *Comprehensive and Appropriate Training.* Except for clinical training, the Philippine program is characterized by large numbers rather than quality of training. Midlevel management and preservice training were not included in the Philippine program for 20 years, although both are key contributors to cost-effectiveness and staff sustainability. Training was also deficient at the field supervisory level, in turn contributing to low prevalence levels for modern contraceptives and high drop out rates.

9. *Effective Information and Communications.* The IEC program can be credited with raising contraceptive knowledge to 97 percent of married couples of reproductive age. But the gap between knowledge and practice was reduced only gradually over the years, and, in this regard, the Philippines in 1988 placed significantly below all nearby countries and all Catholic countries except Bolivia and Haiti.

The 1990 CDIE Study of Sustainability

The team also looked at sustainability using a framework appearing in the draft report of the CDIE multicountry examination of sustainability of health projects (Godiksen 1990).

The team employed six factors derived from those identified in the CDIE report as most frequently associated with sustainability. The six factors are as follows: the economic context, the political context and national commitment, strength of the implementing institution and program integration, program financing and expenditures, training, and mutually respectful negotiation process.

In this analysis (see Appendix D), the following judgments were made with respect to the six factors selected:

1. The economic context: modestly sustained.
2. The political context and national commitment: sustained.

3. Strength of the implementing institution and program integration: sustained.

4. Program financing and expenditures: sustained.

5. Training: sustained.

6. Mutually respectful negotiation process: well sustained.

Aggregating the factor scores, a final average score of 3.00 resulted, meaning that the program could be characterized—in these terms—as "sustained," (keeping in mind that in the CDIE sustainability study scale, there are two levels above the "sustained" level: "well sustained," and "highly sustained").

Summary of Sustainability Findings

The Philippine family planning program, as of 1988, *could be characterized as not in a strong position with respect to sustainability.* The existence of an effective, activist NGO community and a small but experienced and dedicated cadre of government officers in the Department of Health and POPCOM was very important to the program's survivability, but *there was no prospect that it could continue without further, substantial financial assistance from external sources.* The World Bank (1991) has pointed out recently that

> The past Program was never able to establish dependable, long-term financing sources, either domestic or external, although the latter were more readily available and came to have significant influence. In retrospect, Government has never succeeded in establishing a sustainable financing strategy for the Program....

The Department of Health, in its 1988 Annual Report of the Family Planning Service, noted that Outreach had made little progress in the previous 2 years (during which A.I.D. and other external assistance stopped), because of "...serious political, religious, and legislative problems..." (relating to the continuing debate about national family planning policy) and "...institutional, financial, manpower, and logistical constraints" characteristic of the program itself.

In terms of the CDIE definition of sustainability as "the recipient country's ability to continue to support the population program and to provide the same benefits provided by that program following the termination of outside support," *it may be concluded that in 1988, Outreach was moribund, and prospects were not good for a strong national family planning program replacing it without major internal changes and substantial outside help.*

Longer Term Impact

A second major purpose of the Philippines country study was to identify the longer term effects or impact resulting from the family planning program.

Demographic Effects

Population Growth

During most of the 1970s and 1980s, the broad goal of the national population program, with respect to fertility, was "to reduce the population growth rates to levels that promote national welfare and individual well-being." The plan for 1981-1985, for example, according to A.I.D. project documents, was intended to achieve the following:

- Increase the percentage of couples using contraception (the prevalence rate)
- Increase the effectiveness of use
- Promote delayed marriage
- Promote internalization of a norm for small families

None of the USAID/Philippines documents for population projects has explicitly targeted the health-related objectives that form the basis of the current collaboration between A.I.D. and the Department of Health. However, the avoidance of high-risk births may have been an implicit goal of PP I, II, and III.

The field study attempted to examine how indicators of the above outcomes have changed in the course of the population program over the two decades under study and to relate such changes to A.I.D. interventions.

There have been numerous surveys, scholarly analyses, and program evaluations during the past 20 years or so, intended variously to describe demographic changes in the Philippines and to monitor the impact of the family planning program. National demographic surveys were conducted in 1968, 1973, 1978, 1983, and 1988, supplemented by occasional contraceptive prevalence surveys and regional surveys. Additional data are available from the decennial censuses.

In 1990, the World Bank conducted a family planning technical assistance mission to the Philippines and developed an integrated series of estimates of demographic variables. Few developing countries, if any, have a better sequence of estimates over this period.

From 1960 to 1970, the national population increased from 27.1 million to 36.7 million, an average annual growth rate of 3 percent. By 1980 it had reached 48.1 million, with an annual growth rate of 2.7 percent. Preliminary results from the 1990 census give a total of 60.7 million, for a growth rate during the 1980s of 2.3 percent. However, because of emigration throughout this interval, the rate of natural increase is higher than these growth rates would imply, but *there is general agreement that the rate of natural increase has declined substantially.* Moreover, because of population momentum, the population total would continue to increase for several decades even if fertility were to fall immediately to replacement level.

The population has approximately doubled over a generation and is now four times larger than at the start of World War II. Because of urban migration, population growth has been disproportionately concentrated in metro Manila despite the region's much lower fertility than in the country as a whole. About one-seventh of all Filipinos live in metro Manila.

Fertility

Although the crude birth rate has frequently been used as a target for the Philippine population program, the total fertility (TFR) rate is probably the best summary measure of fertility. Table 3 presents the best available estimates of national trends in this indicator (Casterline 1991; UPPI 1990).

The adjusted TFR of 6.18 for 1970 is a convenient baseline figure. Population experts do not believe that a substantial change occurred prior to 1965, and the observed change from 1965 to 1970 was negligible. As stated earlier, a national policy and family planning program began around 1970. During the succeeding 15 years, the TFR declined by 31 percent, to a level of 4.26. This can be expressed either as an average annual geometric decline of 2.5 percent or as an average annual arithmetic decline of 0.13 of a child. The decline was not steady, but was most rapid between approximately 1970 and 1975, and again between 1980 and 1985.

Table 3. Total Fertility Rate in the Philippines, Calculated for 5-Year Intervals, 1965 Through 1985

	1965	1970	1975	1980	1985
Unadjusted TFR[a]	6.20	5.92	5.20	4.96	4.28
Unadjusted TFR	5.72	5.97	5.24	5.08	4.26
Adjusted TFR[b]	6.29	6.18	5.38	5.09	4.26

[a]Total fertility rate (TFR) is the estimated number of lifetime births to a woman experiencing current age-specific fertility rates. It is calculated for the 5 years prior to surveys conducted in 1968, 1973, 1978, 1983, and 1988. For example, the figure given for 1965 is based on the interval 1963-1967, using data from the 1968 survey. The first set of unadjusted estimates is given by the University of the Philippines Population Institute (1990); the second set is given by Casterline et al. (1988, Table 4) for 1965 and 1970 and by Casterline (1991, Table 2.4) for 1975, 1980, and 1985.

[b]The adjustments correct for apparent biases in the sampling frames of these surveys. The adjusted figures for 1965 and 1970 are given by Casterline et al. (1988, Table 4). The adjusted figures for 1975, 1980, and 1985 are given by Casterline (1991, Table 2.4).

The decline from 1970 to 1985 can be expressed as a progression toward the replacement-level TFR of 2.1 children: 4.26 is 47 percent of the way from 6.18 to 2.10. That is, about one-half of the decline to replacement fertility occurred during PP I, II, and III. Thus, based on the 1970-1985 rate of decline, replacement-level fertility would be reached sometime between 2002 and 2014, depending on whether one projects a steady arithmetic decline of 0.13 of a child or a steady geometric decline of 2.5 percent. If the more accelerated rate of decline between 1980 and 1985 is projected, replacement fertility would be reached sometime between 1998 and 2005.

Despite criticism and pessimism concerning the family planning program, there is clear evidence of fertility decline, the ultimate program objective.

In a recent analysis of the demographic impact of family planning programs, Bongaarts et al. (1990) state that between 1960 and 1965 and 1980 and 1985, TFR declined by 1.9 in the Philippines. During the same period, 27 out of the 79 countries in their analysis experienced a decline of 1.9 or more. The authors report the following declines for the three other countries in Southeast Asia that are most comparable to the Philippines: Thailand, 2.9; Malaysia, 2.8; and Indonesia, 1.3.

Contraceptive Prevalence

Table 4 gives the percentage of currently married women ages 15 to 44 using contraception at the time of each of the national demographic surveys conducted from 1968 to 1988.

To see the trends in contraceptive prevalence in the Philippines it is important to distinguish between three groups of methods: program methods with high use-effectiveness (primarily pill, IUD, and female sterilization); program methods with low use-effectiveness (primarily rhythm and condom); and nonprogram methods (primarily withdrawal). This distinction has not been drawn consistently in earlier studies, leading to confusion about trends. Program methods, particularly modern methods or methods with high use-effectiveness, have shown a steady increase. Less effective program methods and nonprogram methods have remained at almost constant levels of use since 1968.

In summary, and discounting the figures for rhythm, condom, and withdrawal in the 1978 survey (see footnote to Table 4), the changes in contraceptive use from 1968 to 1988 have been as follows:

- Prevalence of modern methods increased by about 1 percent annually, from 2 percent in 1968 to 21 percent in 1988.
- Female sterilization is the most favored method, with a 20-year increase from 0 to 11 percent of currently married women, but virtually all of the increase in this method occurred between 1973 and 1983.
- The pill became rapidly established in the first interval but has been stable at a level of approximately 6 percent since 1973.
- The IUD has remained stable at a very low level of approximately 2 percent. As noted, use of male sterilization and injectables has remained negligible.
- The percentage using less efficient program methods showed little change; rhythm increased from 6 percent to only 8 percent, and condom only from 0 to 1 percent, despite massive efforts to promote these two methods.
- The percentage of married women using nonprogram methods (primarily withdrawal) showed little change throughout the interval, remaining in the vicinity of 6 percent.

Table 4. Percentages of Married Women in the Philippines, Ages 15-44 Using Contraceptives, Measured Every 5 Years, 1968 Through 1988

	1968	1973	1978[a]	1983	1988
All Methods	15	17	(38)	32	36
Program Methods	8	14	(26)	26	30
Modern Methods[b]	2	10	13	18	21
Pill	1	7	5	5	7
IUD	1	3	3	3	2
Sterilization	0	0	6	10	11
Other Methods	6	5	(13)	9	9
Rhythm	6	4	(9)	8	8
Condom	0	1	(4)	1	1
Nonprogram Methods	7	3	(12)	6	6
Withdrawal	6	3	(10)	4	5
Others	1	0	2	1	1

Source: Casterline (1991).

Note: Discrepancies in totals are due to rounding. The sampling error for percentages in this table is approximately ±1 percent.

Also, for consistency with the recent World Bank report, this table refers to ages 15-44 and therefore differs slightly from some other reports based on ages 15-49. To maintain the 5-year spacing, the table omits a 1986 national prevalence survey. Except for apparent exaggeration of use of rhythm and nonprogram methods, that survey showed close consistency with the 1988 National Demographic Survey.

[a]It is believed that the 1978 survey overestimated the number of current users of rhythm, condoms, and withdrawal. Measurements of earlier or recent use of these methods can be difficult to distinguish from current use, and estimates are sensitive to the specific wording of questions. (In the view of some researchers, however, surveys other than those conducted in 1978 and 1986 have underestimated the use of withdrawal.) Figures involving these estimates for 1978 are given in parentheses.

[b]Male and female sterilization are combined; in each survey, fewer than 1 percent of couples reported use of the former. Injectables are also a program method, but in each survey, fewer than 1 percent of married women reported using them; they are included in the total, but are not listed separately.

Because of changes in the wording of some questions, the 1978 survey results probably exaggerated the current use of rhythm (including natural family planning), condom, and withdrawal. This change in measurement is not merely

of technical interest; it had a serious impact on the program that merits some discussion.

The inflated measurement of less effective methods in the 1978 survey gave the impression of a major increase in overall prevalence between 1973 and 1978. The percentage of women using modern methods had increased modestly from 10 percent to 13 percent, but when all other methods were added in, prevalence more than doubled, from 17 percent in 1973 to 38 percent in 1978. POPCOM and A.I.D. were eager to take credit for this apparent increase, even though withdrawal was not a program method and rhythm and condom were known to have relatively low levels of use-effectiveness.

Subsequently, when the 1983 survey results became available, it appeared that the trend had reversed and that overall use of contraception had declined substantially between 1978 and 1983. The percentage of women using modern methods had again increased, from 13 percent to 18 percent, but the measure of total prevalence fell from 38 percent to 32 percent. Program opponents used this spurious data, the most current available during the last 2 years of the Marcos Government and the early years of the Aquino Government, to discredit the program by associating it with other failures of the Marcos regime. The decline in total prevalence was widely quoted by the press, as well as in many official reports. The result was serious damage to the reputation of the family planning program and to the morale of staff.

It was an explicit purpose of the national program to improve the method mix. If nonprogram methods are included, the mean use-effectiveness increased from 0.76 in 1973 to 0.79 in 1988. If only program methods are considered, the mean use-effectiveness increased from 83 to 85 across the 15 years. (These calculations employ the following use-effectiveness scores of specific methods: sterilization, 100; IUD and injection, 95; pill, 90; rhythm, 70; condom, withdrawal, and other methods, 60.) Therefore, whether the nonprogram methods are included, there was only a modest improvement in method mix, even with the substantial expansion of sterilization.

An increase in prevalence should lead to a subsequent decrease in fertility, and it is indeed observed that the largest declines in fertility were one interval later than the biggest increases in modern contraception. This pattern is even clearer if the inflated prevalence rate for 1978 is scaled down to a more plausible level. Because of very little change in nuptiality and the duration of breastfeeding,

most of the declines in fertility in the Philippines can be attributed directly to the increases in prevalence.

If the current relationship between prevalence and fertility is projected, replacement fertility (TFR of 2.1) will be reached by the time the prevalence rate is 60 percent or even less. Data from other countries would usually imply that a prevalence level of about 70 percent is required for replacement fertility. The steeper returns to prevalence in the Philippines raise the possibility of either an underreporting of use or a more effective use of such methods as rhythm than is typically observed.

Proximate Determinants of Fertility

Besides contraception, there are three other proximate determinants that account for most variation and change in fertility levels: nuptiality, breastfeeding, and abortion. With respect to nuptiality, although it has in fact been an explicit part of the Philippine family planning policy to delay early marriage and early childbearing, there was no significant trend in marriage patterns during the 1968-1988 period. About 94 percent of women eventually marry, and the singulate mean age at marriage ranged between about 23.4 and 24.5 during the interval from 1968 to 1988. The most recent estimate, from the 1988 demographic survey, is 23.8. This relatively high age at marriage, especially for a developing country, is related to the unusually high level of female education in the Philippines.

The surveys are inconsistent in their measurement, but suggest a decline in the mean duration of breastfeeding, although not in the percentage of children who are breastfed (between 83 and 84 percent during the 1970s and 1980s). It is estimated that the mean duration of breastfeeding declined from 13.3 months in the mid-1970s to 9.9 months in the mid-1980s, with a lesser reduction of the period of postpartum amenorrhea from 8.2 months to 7.8 months (Casterline 1991). The impact on fertility of observed changes in breastfeeding is negligible.

Data on induced abortions are almost nonexistent. Some areas report indirect evidence of an increase (e.g., increases in hospital admission for septic abortions), but it is impossible at present to estimate levels or changes in induced abortion and the degree to which it may be used when there are contraceptive failures or when abortion is used as an alternative to contraception.

Desired Family Size and Unmet Need for Family Planning

The estimation of desired family size is problematic. If asked directly about their personal preferences, women with large families will tend to state a preference for large families, partly to justify or rationalize the size of their own large families. More sophisticated measures are based on survey questions about whether the last child was wanted. Using these methods for the 1978 and 1988 national surveys, the World Bank (1991) estimated that the "wanted TFR" was 3.21 immediately (during the 24 months) before the 1978 survey and 2.92 immediately before the 1988 survey. For the same reference periods, the adjusted TFR was 4.96 and 4.07, respectively. These figures imply the following:

- From 1978 to 1988, the decline in desired family size was less than the decline in the TFR.
- By 1988, the desired family size was still substantially in excess of the replacement level of 2.1.
- By 1988, the gap between observed and desired fertility (1.15) was less than it had been 10 years earlier (1.75).

The World Bank report (1991, Table 3.3) gives an estimate of unmet need, that is, of the percentage of currently married women ages 15-44 who are not using but are in need of contraception, based on their statements about desire for more children or the degree to which the last birth was wanted. Using the method developed by Westoff, about 20 percent of women in the 1988 survey were in need of contraception to limit the size of their families and about 19 percent for spacing purposes. There is some controversy among demographers as to whether the inclusion of women who want to space their children may overstate the extent of unmet need. However, using even a very conservative interpretation of these data, contraceptive prevalence could rise to 60 percent in the Philippines and unmet need would still not be completely satisfied.

Health Effects

Aggregate indicators of health status have improved over the past two decades. Life expectancy rose, although modestly: for males, from 58 to 60 years; for females, from 63 to 66 years. The infant mortality rate declined from about 69 in 1,000 live births in 1968 to between 45 and 51.5 per 1,000 live births in 1991.

Certain categories of births are known to carry higher health risks for the mother or the infant or both. It was not consistently an explicit objective of the program to reduce high-risk births, but it was certainly an implicit objective. High-risk categories include births to women below age 20 (especially below age 18), at ages 35 and above, with four or more children, or within 2 years of a previous birth.

Concerning the 15-19 age group, as discussed above, there has been no trend toward delayed marriage; the age-specific fertility rate has remained steady. All the surveys show about 50 births per 1,000 women. These figures have been adjusted upward for underreporting to about 72 births per 1,000 women in the age interval (see Casterline et al. 1988, Table 4). The adjusted figure corresponds to an average of about 0.36 births per woman before age 20. Because fertility declined in other age intervals, the fraction of all births in this interval has increased, even though the level has remained constant. Even so, in 1985 only about 8 percent of the TFR was attributable to births before age 20—a smaller percentage than in the United States, for example. There are recent reports of an increase in premarital births in urban areas. Such evidence is important because of the especially high probability of infant or maternal mortality when early births are nonmarital.

Second, consider births after age 35, for which the incidence of birth defects is considerably higher. In 1970, the age-specific rates implied an average of 1.6 births per woman after age 35. By 1985, the figure had fallen to 1.0, a decline of 36 percent (Department of Health 1990).

Third, higher risks are associated with higher order births, especially for fourth and later births, because they tend to occur at later maternal ages, they imply greater competition for parental resources, and they weaken the mother biologically. Order- and period-specific fertility rates are not consistently available from the Philippine surveys, but the declines in total fertility and in late births clearly imply major reductions in this category of high risk.

Fourth, a higher risk is associated with shorter birth intervals. Intervals less than 2 years long tend to damage the health of the mother and of both the newborn infant and the preceding child. Reversible contraceptive methods will increase the length of an interval, even when there is a contraceptive failure. Trends in birth intervals have also not been consistently calculated.

In summary, of the high-risk birth categories, the age-specific fertility rate for ages 15-19 has remained steady, with only 8 percent of the TFR attributable to

births before age 20—less than in the United States. On the other hand, recent reports suggest an increase in premarital births in urban areas, of concern because nonmarital births carry very high probabilities of infant and maternal mortality. Concerning births to women above age 35, over the 1970-1985 period, age-specific average rates showed a 36 percent decline. Order- and period-specific fertility rates are not consistently available, but the declines in total fertility and in late births point to major reductions in this category of high risk.

Economic and Social Factors

In his memorandum of 1991, Thomas Morris quotes T. Paul Schultz:

> A lesson learned over the last two decades by family planning managers in different countries is that the success of family planning depends heavily on the underlying changes in the economic and social environments which motivate couples to "demand" fewer births.

Many factors—social, economic, religious, and demographic—may affect fertility. They include such things as education, industrialization, urbanization, income level and distribution, status of women, labor force composition and structure, religious and ethnic affiliation, and modernization. It has not been possible to study these in any depth, and in any case, quantitative measures of many are not available. Nevertheless, some observations may be made concerning several of these factors.

Situated on the rim of the Asian landmass, the Philippine Islands have been deeply influenced by Western culture and ideas, particularly economic and political values. Yet, like other Asian peoples, and despite modernizing influences, Filipinos have held tenaciously to the family as the focal point of their life strategies. Thus, population programs focused on family welfare have a greater chance for success than those grounded totally in demographic targets, a fact that was not fully appreciated by Filipinos and U.S. citizens working in the family planning program in its early years.

Most of the Philippine population effort was dominated by POPCOM, whose rise, growth, and decline resembled the pattern of the Marcos dictatorship. POPCOM was unable to disassociate itself from its founder. Conversely, the

Church resisted Marcos's usurpation of power and eventually played a key role in the return to democracy. These unique roles of POPCOM and the Church have played a significant, albeit unquantifiable, part in the development of the family planning program. On the one hand, POPCOM made the concept of planning one's family familiar to couples throughout the country. On the other hand, the Church played an important role in preventing social marketing and causing a hiatus in the public and NGO family planning programs for almost 3 years. In no other Catholic country has the Church been in such a strategic position to exercise its influence on the course of a national family planning program.

Women have higher status in the Philippines than in any other country in the world, with the possible exception of Finland and the Scandinavian nations; only in the areas of maternal health and life expectancy do statistics for Filipino women fall below developed country standards. Their educational and literacy attainments are within one point of their male counterparts, and women actually outnumber men at the university graduate level. They are highly respected members of the legal establishment, the medical profession, and the academic community. While not equal to men in numbers on the political scene, they have achieved recognition as important leaders. Women are also prominent in the media. In the key area of family structure, they are the usual keepers of the purse and increasingly the sole breadwinner. Filipino women have great freedom of movement, an independence from immediate family control unlike what women in nearby Asian countries enjoy.

In recent years, women—particularly nurses and teachers—have taken employment abroad. Their younger, less educated, unmarried sisters at home have migrated in large numbers to the cities, particularly to Manila. In fact, 58 percent of new migrants to Manila are women. Nevertheless, despite the high status and independence of Filipino women, both desired and completed family size remain higher than for less advantaged women of neighboring Asian countries.

While macroeconomic policies biased toward capital intensive development, unequal ownership of assets, and inadequate social structure have contributed to the high incidence of poverty and underemployment in the Philippines, rapid population growth adds three-fourths of a million members to the labor force every year, faster than jobs become available. Although it has not been quantified, some of the drop in TFR will translate to a smaller number of new entrants into the labor force than would otherwise be the case.

Such positive, although modest, changes will be especially important in the cities, where not only has the economy failed to provide remunerative employment to new labor force entrants, but where the greater numbers of the poor have diminished access to health and other social services and housing.

Using the L-M 30-component scale of program effort, Bongaarts et al. (1990) rated programs in 79 mostly developing countries as of about 1982. Out of four categories (strong, moderate, weak, and very weak), the Philippines was ranked in the "moderate" category. The authors also classified the Philippines as of 1980 in the "upper middle" category of their "development index," following a procedure proposed by the United Nations. This index is based on four variables for which estimates were available in a large number of countries in 1980: one economic measure (gross national product per capita), one health measure (infant mortality rate), one education measure (gross enrollment ratio), and one communication measure (a composite of the number of televisions, radios, and automobiles per capita). On the basis of total scores assigned, countries were divided into four categories: high, upper middle, lower middle, and low.

Only 13 countries were in a higher category than the Philippines on one or both of these two predictors. However, shortly after 1980 a serious economic downturn began in the Philippines. Nevertheless, one would expect that based on its relatively higher initial socioeconomic levels, the Philippines would have made more pronounced progress in lowering total fertility than was the case. But a comparison of fertility decline among countries in the region shows that the fertility decline over the past 20 years has been significantly greater in Thailand and Indonesia, where TFRs have fallen by 3.3 and 2.2 births, respectively, and CPRs were 68 and 48 percent in 1987. Socioeconomic differences among the three countries should have contributed to better, not lower, relative performance by the Philippines.

Unpublished tabulations from the 1988 National Demographic Survey (Zablan 1991), and summarized in Table 5, describe variations in prevalence among currently married women ages 15-44 in different categories.

Table 5 suggests that by 1988, prevalence—and particularly the prevalence of program methods—was substantially higher for women who were urban, better educated, aged 35 or older, or with four or more children than it was for other women. In view of the active disapproval of the Roman Catholic Church of methods other than rhythm, it is notable that it is Muslim women who are not using contraception, while there is virtually no difference in prevalence or in method mix between Roman Catholics and non-Muslim, non-Catholics.

Table 5. Contraceptive Prevalence Among Subgroups of Currently Married Women, Ages 15-44, in the 1988 National Demographic Survey of the Philippines (percentages)

Category	Program Methods		Nonprogram	Total	Percentage of Total Sample, by Subgroup
	Modern	Other			
All	21	9	6	36	100
Rural	18	8	6	32	61
Urban	26	10	6	42	39
Age <20	7	2	2	11	4
Age 20-34	19	8	7	34	60
Age 35+	24	11	5	40	36
<4 children	15	7	5	27	61
4+ children	26	9	7	43	39
Primary	14	4	5	22	13
Intermediate	19	6	8	32	33
High School	24	9	6	40	33
Some College	24	12	7	43	9
College Degree	23	18	4	45	12
Muslim	3	1	1	5	4
Catholic	22	9	6	37	84
Other	22	9	6	38	12

Source: Zablan 1991.

Other Factors

Reductions in the TFR can positively impact on the deteriorating environment, but even in the near term will be only illustrative of what might be possible if gains in CPR continue to be made. According to World Bank (1991) data, rapid population growth over the past three decades has had a particularly deleterious effect on rural and coastal natural resources. Since the agriculture, fishery, and forestry occupations employ one-half of the labor force, generate 40 percent of

export earnings, and contribute one-fourth of gross domestic product, deterioration of the environment is especially serious.

However, in recent years, family planning services for groups causing the most severe environmental degradation (the upland shifting cultivators) have been unreliable or nonexistent. Encouraging contraceptive use among upland families is a sizable task; with unrestricted access to land, farmers need additional children to help them clear the land for farming.

Summary of the Longer Term Effects

To give an overall assessment of the impact of the program, it is essential first to recognize that, as in any country, some changes observed in the Philippines can be attributed to the program itself, but other factors were also at work. Some of these other factors, such as the continuing high level of female education in the Philippines and exposure to Western ideas through the media, favored improvement in CPR independently of the program. The 1988 demographic data (Table 5) strongly support the finding that the higher the level of female education, the higher the CPR. The prevalence levels for modern methods for women of urban areas—where modernizing influences are strong—are higher than for women of rural areas. Other factors, such as the formal opposition of the Roman Catholic Church to methods other than rhythm, may have inhibited improvement, although the 1988 data suggest otherwise. Table 5 shows that it is Muslim women who are not using contraception.

Use of Poorly Justified Targets

Changes, such as in contraceptive prevalence, can be expressed relative to a previous point in time or to a goal stated at the beginning of a given time period. This distinction is particularly important for the Philippines. POPCOM established goals and targets for successive 5-year plans. With almost no exceptions, these plans were based on unrealistic assumptions about both past and future successes. As a result, the program continually appeared to be doing badly whenever new data became available (except when the high prevalence estimates from the 1978 survey were released).

The use of poorly justified targets contributed to the image of POPCOM as ineffectual. It also led to the occasional inflation of measures of success, for

example, by attaching much more importance to new acceptors than to continuing users and counting women who had merely resumed use of contraception after a brief interruption as new users. Actually, prevalence was increasing steadily, if not rapidly, and fertility was declining steadily through the 1970s and 1980s. There were substantial changes, even if less than targeted. For purposes of this report, it is irrelevant that the program fell short of its own largely artificial targets.

In our view, the national program had important strengths during most of the interval under study. As is described elsewhere in this report, it accomplished a great deal in terms of developing an infrastructure for motivation and service delivery and for training personnel.

Program Impacts

A primary role of A.I.D. was to provide condoms and pills and to help develop a logistical system for resupply of these methods. However, it is not clear that the demand for these methods has been high. Table 4 shows that during the 1973 to 1988 interval, despite the establishment of a network of 52,000 volunteer barangay service point officers to distribute stocks of pills and condoms, there was no increase in the percentage of women actually using pills or condoms; the percentages remained at about 7 percent and 1 percent, respectively. The 1978 and 1983 national demographic surveys both showed pill use as only 5 percent; the 1978 survey is the only one to suggest that condom use ever rose above 1 percent. The IUD, another method promoted by the program, remained steady at 2 to 3 percent throughout the 1973 to 1988 period. The only significant increases in these three methods occurred *before* 1973.

Although the percentage of women using these methods did not change much, it should be noted that the actual *numbers* of couples and current users (of these methods) increased by nearly one-half from 1973 to 1988. Because of cohort replacement, the users in 1988 were almost completely a different group than the users in 1973. For these reasons, as well as because the same individual can be counted several times as a new acceptor, more than 5 million new acceptors of pills, condoms, and IUDs were recorded from 1973 to 1988. Nevertheless, it seems reasonable to evaluate performance more in terms of increases in prevalence than in terms of new acceptors. Simply maintaining the delivery mechanisms available in 1973, with sufficient increases in supplies and outlets to keep

pace with population growth, should have sustained the prevalence observed in 1973.

It is also known that a substantial portion of the resupplying of contraceptives is done independently of the national program. The World Bank (1991, 94) cites studies by the Futures Group-SOMARC in which "an estimated 1.6 to 2 million pill cycles and 2 million condoms were sold in 1989 through some 6,000 pharmacies and 364 supermarkets, implying that commercial sales account for 27 percent of the oral contraceptive market and 16 percent of the condom market." This is roughly consistent with 1988 Demographic Survey findings that "...nearly 30 percent of contraceptive users obtained their last supply from a salesperson..." (Zablan 1991).

During the lengthy interval in which the percentages of couples using the pill, condom, and IUD have remained stagnant, sterilization (almost entirely tubal ligation) increased from 0 to 11 percent. From 1973 to 1988, there were reported increases in the use of rhythm, which has never been emphasized by the program and was not originally a program method, and in withdrawal, which has never been a program method.

These observations suggest several conclusions regarding the impact of the program. First, *disproportionate resources may have been devoted to supplying methods—pills, condoms, and IUDs—that apparently appealed to only a small fraction of Filipino couples.* The use of these three reversible methods has hovered around 10 percent (combined) throughout a 15-year interval, and nearly 30 percent of the pills and condoms are being obtained commercially rather than through the program. The lack of appeal of these methods has also been reflected in higher discontinuation rates in the Philippines than in most other countries. Despite such evidence, even relatively conservative targets currently being circulated (Department of Health 1990) continue to project steep rises in the use of each of these three methods, with their combined prevalence increasing to 15 percent by 1994. An increase may occur, of course, but it is impossible to extrapolate one from the known historical trends. It is also possible that there is indeed a greater demand for reversible contraception and that some other method, such as Norplant, will meet this need and be culturally acceptable.

Second, as a related point, *the program was not effective in increasing the demand for these reversible methods.* These contraceptives were available at no charge to large numbers of potential users from the mid-1970s until the late 1980s. However, economic development, often a source of demand, was not

taking place, especially in rural areas; apparently the program was unable to act independently of the economic situation to generate demand.

Why has so little notice been taken of the absence of any increase in the demand for modern reversible methods? Probably the main reason is that the distribution of large quantities of supplies and other program outputs have been required simply to maintain the status quo—that is, the prevalence level that existed in 1973. Moreover, the number of so-called new acceptors has always been large because of the unusually high drop out rate and the subsequent reinstatement of these dropouts as new acceptors. The number of new acceptors and continuing users has indeed increased over time, although simply as the population at risk has increased.

A third conclusion is that *the impact of the program lies mainly in whatever contributions it has made to the use of female sterilization and rhythm.* These are the only program methods to show evidence of increasing use and demand. The role of USAID/Manila has been substantial in the training of doctors and nurses in surgical sterilization, and the Outreach program has unquestionably helped to motivate the use of this method. Unfortunately, it is difficult to quantify this impact. A high proportion of tubal ligations has been carried out at NGO clinics and, similarly, it is mainly NGOs that have promoted the various forms of rhythm. Innovations in sterilization—for example, the use of itinerant teams—appear largely to be due to NGOs rather than to the Government program. Within the Government program, all tubal ligations are carried out in Department of Health clinics and these clinics specifically advise against rhythm because of its lower use-effectiveness.

Another conclusion, very important, is that *paradoxically, fertility has continued to fall in the Philippines at the same time that prevalence has increased only modestly.* It is possible that the use-effectiveness of the nonsupply methods, particularly rhythm and withdrawal, has increased. It is also possible that supply methods such as the pill are being used more effectively and continuously than in the past. As an alternative explanation, perhaps the correct inference to be drawn from the high levels of rhythm and withdrawal reported in the 1978 survey is that they result from *better* questions and interviewing in that survey. That is, it is possible that the actual use of these methods is higher than reported and is increasing. Alternatively, it is possible that other proximate determinants have been changing, for example the amount of spousal separation (due to increasing internal migration and emigration) and the use of induced abortion. Whatever the

explanation, fertility appears to be decreasing and at a rate that cannot be accounted for by the methods in which A.I.D. has made its greatest investment.

A final conclusion about the Philippines' program is that *there has been a remarkable absence of research* on the demand for children, the demand for specific methods and types of services, the cultural acceptability of those methods and services, the impact of the program upon demand, and ultimately the impact of the program upon continuing use of contraception. The team encountered little evidence of attempts to merge and reconcile the following kinds of information about demographic change: (1) service statistics from the government and private sectors regarding the distribution of supplies and services and the numbers of new acceptors and current users; (2) survey data on the prevalence of specific methods and sources of supplies; and (3) survey data on actual fertility. Casterline et al. (1988) and Pullum (1988) have successfully attempted to reconcile the estimates of fertility and contraception in the major surveys (prior to the 1988 National Demographic Survey) with one another. These efforts have focused on establishing consistent time series for fertility and the proximate determinants, and have included some linkages between fertility and the proximate determinants. However, explicit linkages between service statistics, on the one hand, and prevalence levels and fertility levels, on the other hand, have been virtually nonexistent.

A neglected and an important research question is, To what extent are nonsupply methods being used by the poorer classes? One factor, to be inferred from the team's interviews of acceptors, is that poverty levels (the proportion of the poor has remained constant since 1971) have influenced couples to try to limit family size. The foregoing kinds of research could have been carried out within POPCOM or could have been commissioned to a variety of competent institutions.

There has been a good deal of demographic research, but it has generally not linked users or potential users to the infrastructure established by the program. An exception was Laing's follow-up surveys of clinic-based acceptors in the early 1970s to measure continuation and use-effectiveness. Indicative of the kind of research needed, although coming after 1988, the recent analysis by Zablan (1991) relates the responses of individuals in the 1988 Demographic Survey to information about local community characteristics, including the service facilities in the community. Other researchers such as de Guzman are currently conducting in-depth interviews and using focus groups to identify reasons for use and nonuse of contraception, but results are not yet available.

Performance indicators have not received enough attention, both in terms of depth and frequency of measurement. Within POPCOM and A.I.D. there has been a preoccupation with artifacts of the structure of the program, rather than with the bottom line: the number of continuing users and the level of fertility. Up and down the system, for example, performance has been measured in terms of the number of new acceptors, with very little concern for an acceptor's age and parity, how many times she has already been counted as a new acceptor, how long she will continue, or what she is using. Performance was also measured in terms of supplies acquired, moved, and exhausted. There has been a preoccupation with the procurement and logistics of distributing a variety of pills and, to a lesser degree, a variety of condoms.

Major Conclusions

This section reports the major conclusions drawn from A.I.D.'s participation in the Philippine national family planning program.

A.I.D.'s Close Identification With the Philippine Program

A major conclusion is that over the 20-year period under study, the family planning activities supported by USAID/ Philippines and those of the Philippine national program were virtually indistinguishable. A related conclusion is that when a donor gets this closely identified with a partner country effort, it shares both the credit and criticism for what transpired.

Lack of a Long-Term Strategy

The evaluation showed that neither the Government nor A.I.D. was able initially to approach Philippine population issues in terms of committing resources and being engaged over many years in what might be termed an intergenerational program. There are many reasons to explain why this did not happen, including donor reluctance to be tied into open-ended arrangements in the context of political uncertainties, cultural sensitivities, lack of human and fiscal resources, and so forth.

The experience of the Philippines, together with what we have learned elsewhere about family planning, confirms that creating an effective, efficient, and sustainable family planning effort is not a one- or two-project undertaking. Establishing a viable family planning program requires that A.I.D. face all of the institutionalization issues familiar to other sectors and commit resources of sufficient size to those countries where political and cultural factors are judged favorable to such a continuing engagement. Long-term commitment makes possible the creation of a multiyear strategic plan, in which other donors are encouraged to participate in specific ways.

There can be little doubt that the Philippine family planning program became a kind of "political football." Its future was never very secure because the Philippine leadership was not required by A.I.D. and other donors to seek compromises and create a national coalition and supportive policies and funding to ensure the continuation of some minimum program. Had that been the approach, and had it been followed, family planning in the Philippines *might* have been more successful than was the case.

There is of course no way to know. We also do not know the extent to which the American contribution was misapplied in the absence of such a long-term approach. However, it is reasonable to conclude that A.I.D.'s large investment would have been more carefully applied, with greater prospects for success, had the Agency made its support contingent on achievement of the kinds of conditions noted above.

Training

Training received much attention, with thousands of course hours logged during the 20-year period under study. Training funds, averaging P18 million during the 1980s, dropped to below one-fourth of that level in 1987 and 1988, virtually disappearing the following year. This was unfortunate, and by 1988 normal attrition and emigration had reduced the ranks of workers at all levels, seriously undercutting program sustainability.

Moreover, training was uneven in quality. On the one hand, VSC training was so outstanding that top-flight surgical contraception teams were dispatched to train local VSC teams in Africa and other Asian countries. On the other hand, preservice family planning training for students of nursing, midwifery, and medicine was never established, and management training for senior and midlevel administrators was neglected. Also, the training of field-workers was so superficial that many did not know the differences among the various contraceptive methods, particularly the health benefits of the most effective methods. It was concluded that despite recurrent reports of failure of training to equip field-workers to improve their performance, their training programs changed very little. For example, there is no evidence that changes were made in training to solve the three continuing problems of high drop out rates, knowledge-practice gaps, and choice of ineffective contraceptives.

Recently there has been an increase in the use of effective contraceptives, but we conclude that this is due to users learning by failure, rather than to revised training, improved IEC, or other program adjustments.

Role of Nongovernmental Organizations

NGOs have been very important in initiating and sustaining family planning in the Philippines, serving as the earliest advocates, before the national program began, and continuing a constructive involvement to the present. A.I.D. supported NGOs in the late 1960s, when it funded the Institute of Maternal and Child Health, the Asian Social Institute, the Family Planning Agency of the Philippines, and the Planned Parenthood Movement in the Philippines.

NGOs have been the principal institutional force for innovation and training outside the Government. They were especially influential in pioneering the use of VSC; a high proportion of tubal ligations was carried out in NGO clinics. Similarly, it was mainly the NGOs that promoted the various forms of the rhythm method. NGOs also initiated adolescent fertility management projects that focused on sex education. NGOs led the way in the rapid expansion of clinical services, operating nearly 15 percent of all family planning clinics and compiling impressive records in servicing acceptors, because they maintained qualified staffs, adequate supplies, and were open 7 days per week.

On the one hand, we conclude that had the Government, A.I.D., and other donors planned for the best utilization of the NGOs, capitalizing on their substantial strengths and finding ways to compensate for their weaknesses, these organizations might have been even more effective. On the other hand, it is reasonable to conclude that had these private sector organizations not participated in family planning, the Philippine program would have enjoyed much less success, and might have disappeared altogether. It has been amply demonstrated that given suitable support and encouragement, NGOs can be a vital, constructive force in family planning in developing countries. One of their major strengths—in the Philippines as elsewhere—is that in tapping indigenous technical and material resources, they build a constituency for the program that can insulate family planning from episodic political and other societal change.

Financial Self-Sufficiency

A sustainable financial strategy was never developed. From its beginning, the Philippines family planning program lacked adequate in-country resources to cover recurrent costs. External funding supported 85 percent of expenditures during the program's first 4 years, and, without it, the program could not have begun when it did. Donors provided almost 57 percent of total program expenditures from 1970-1988, of which A.I.D. contributed two-thirds.

The financial contribution of the Government remained less than anticipated under various agreements with donors. In PP III, the Government's share was to have been 70 percent of clinic support services costs, but dropped to barely 40 percent from 1984 to 1988. In a project funded by the International Development Association, the Philippine share was 44 percent of total costs, but only 39 percent was forthcoming.

The planning for Outreach saw nonfederal monies as playing a major role in case outside sources dried up. By 1988, local government units were furnishing about one-third of total program costs, well below what more optimistic projections had anticipated. There is general agreement that eventually the provision of family planning services should not require support from external donors and ultimately not even the support of the Government. But, as of 1988, the national program was particularly fragile, and if the objective was to continue to work for further reductions in total fertility rate (TFR) and gains in the contraceptive prevalence rate (CPR), it would have been unrealistic for donors to require the Government to provide a greater share of program costs, or for the Government to transfer more financial responsibility to local governments.

The Philippine experience leads to the conclusion that for family planning programs to achieve sustainability—managerial, institutional, and financial—host countries and donors have to plan for and pursue this objective systematically. The related conclusion is that developing countries cannot bear an increasing part of the burden of financing a massive family planning program without sustained economic growth.

Setting Well-Defined and Realistic Targets

The study concluded that each element of the program should have had targets that went beyond immediate outputs—such as training a specified number of personnel or distributing a specified number of condoms per year. However, targets also should not be too far removed from the program, as in the case when they are specified in terms of the population growth rate (which is affected by the balance between births and deaths and by the age distribution). Reasonable target variables would be, for example, the age-specific fertility rates for the youngest and oldest ages, TFR, and CPR, including the prevalence of specific program methods. It was concluded that the Philippine program tended to set targets in terms of indicators that were too distant from the program and that were affected by many factors other than the program.

Targets should not be impossible to achieve. For example, POPCOM set a goal of improving CPR from 24 percent in 1976 to 35 percent by 1980, or about 2.5 points per year. In comparison, Taiwan and South Korea had not been able to do better than 2 points per year. The Philippine program tended to set goals independent of any evidence that they could be achieved, with resulting damage both to the credibility of the program and to staff morale. The CDIE team concluded that much of this damage could have been avoided if targets had been set based on more direct evidence of possible change.

Data for Management and Research

Over the years, evaluations of the various A.I.D. family planning projects and of the Philippine national program (e.g., those of 1978, 1980, and 1986) repeatedly referred to an inadequate management information system. The need for more complete and relevant data, collected on a more frequent basis, was a continuing theme over the years. Given the lag between the various national surveys and evaluations, a strong information system was essential to sound program management. The CDIE team concluded that from the beginning of the program, A.I.D. was ambivalent if not inconsistent in this matter, repeatedly emphasizing the importance of a management information system, but not following through to ensure that it was fully implemented. This was matched by A.I.D.'s inconsistency with respect to efficiency measures. Regular and system-

atic cost analysis, despite having a high priority with A.I.D., other donors, and even Government officials, was basically ignored for 20 years.

Reflecting the problems with the MIS, the most important gap in data collection was the lack of some kind of monitoring or surveillance system based on a national sample of barangays. With such a system it would be possible to rapidly generate estimates of vital events, contraceptive prevalence, and various health indicators.

The CDIE team concluded that one of the strongest features of A.I.D. activities in the Philippines was the partial support of a sequence of national demographic surveys and occasional contraceptive prevalence surveys. It also supported institutions to analyze these surveys and other data, most notably the Population Institute at the University of the Philippines.

Nevertheless, the CDIE team also concluded that there has been inadequate dispersal through the research community of data sets and working papers. A.I.D. or another agency might have helped to extend the infrastructure of data analysis to include more institutions, with resulting benefits for all parties involved. The Population Institute of the University of the Philippines is unquestionably the most competent demographic research organization in the country, yet there would have been benefits from contracting more research to other institutes outside Manila and to some other groups within Manila. A wider range of insights and methodologies would have been beneficial.

The CDIE team concluded that because there was never a longer term research plan, performance indicators did not receive attention, in terms both of depth and frequency of measurement. More detailed questions concerning performance were neglected. Performance was measured in terms of the number of new acceptors, with very little concern for an acceptor's age and parity, how many times she had been counted as a new acceptor, how long she would continue, or what she was currently using. In marked contrast to nearby Asian countries, the Philippines has experienced continuing high discontinuation rates for pills, IUDs, and condoms. This has been true despite the fact that they were available at no cost to the client. Although there is evidence from many end-point providers that their family planning technical training was inadequate for them to provide *quality* care, no serious study was undertaken to determine how this dimension as well as other conditions affected demand for these modern reversible methods.

Within both POPCOM and the A.I.D. Mission, performance was measured in terms of supplies acquired, moved, and used up; there was a preoccupation with the procurement and logistics of distributing a variety of pills and, to a lesser degree, a variety of condoms, rather than with the number of continuing users, the level of fertility, and why people preferred one method over another.

A final conclusion is that both A.I.D. and Philippine national family planning program managers failed to take full advantage of key messages from those data that *did* reach them, for example, from service statistics and surveys of knowledge, attitudes, and practices.

Generating and Supplying the Demand for Services

A program that offers services must also generate demand for them. Potential clients must be aware of the existence and benefits of those services. The Outreach program, which began in the Philippines in the mid-1970s with strong A.I.D. backing, aimed to improve access to supplies such as pills and condoms, but it was also intended to provide an avenue for recruiting new acceptors and generating demand. The conclusion with respect to Outreach is that it was an exciting innovation, but demand generation received very little attention.

Currently, the demand for services—sterilization rather than reversible methods—appears high, but the program can take only some of the credit for this situation. The conclusion here is that if the demand for sterilization has increased during the past decade, it is due to changes in the cultural setting and the perceived costs of children, more than to economic development, which was slow in the 1980s, or to program stimuli, which diminished throughout the 1980s.

Fertility Has Continued to Decrease

Fertility has continued to decrease at a rate that cannot be accounted for by the methods in which A.I.D. has made its greatest investment. Related to this is the conclusion that disproportionate resources may have been devoted to supplying methods—pills, condoms, and IUDs—that apparently appealed to only a

small fraction of couples. The team suggested that the use-effectiveness of the nonsupply methods, particularly rhythm and withdrawal, may have increased beyond what survey data have been able to detect. Other explanations may account for the inconsistency between the apparent decline in fertility and the apparent stagnation in contraceptive use. For example, the survey results for both fertility and contraceptive use are subject to measurement error. Moreover, there may have been increases in unmeasured proximate determinants such as spousal separations and use of abortion.

It may be that this state of affairs is in turn linked to the question, Who is most likely to use the nonsupply methods? The state of the Philippine economy, and especially the incidence of poverty, may offer clues to an answer. Data show that while fertility is higher and contraceptive use lower among poorer households, it has been demonstrated that demand for contraception is high among these families. Perhaps the best conclusion is that for reasons of inaccessibility of modern methods, or unwillingness to use them, poorer households have turned to the nonsupply methods.

The team's interviews of acceptors, many below the poverty level, showed that when asked why they wanted to limit family size, mothers said they could not afford to have more children, or that they wanted to educate the children they had. If this anecdotal evidence is a sample of widely held convictions, then we may conclude that decreased fertility may be the result of greater use of nonprogram methods such as rhythm and withdrawal, particularly among the poorer couples. This contraceptive choice may have been the result in some cases of the lack of available free contraceptives at Department of Health and NGO clinics in recent years.

Role of Mission Staff

Both U.S. and Filipino professional staff of the local Mission are critical to the success of the program. They play a key role in coordinating the activities of other donors and helping the diverse actors in the population field to communicate with one another and develop a coherent program. The CDIE team concluded that in a field of such technical and programmatic complexity as population, the Mission needed family planning expertise if they were to be credible in dialog with Philippine specialists and successful in managing the assistance provided by A.I.D.

At several key points during the past 20 years, according to Filipinos who have been active in the program, the Mission staff were exemplary in this role, serving as a resource to the Government. However, these same Filipino officials felt that at certain times A.I.D.'s representatives were limited to monitoring budgets and performing mostly bureaucratic functions, not able to participate actively as peers in discussing issues and developing new program concepts and approaches. These officials pointed out that given the size of the A.I.D. investment in the critical population sector, Mission staff should have been maintained in both sufficient numbers and with strong professional credentials of training and experience so that this deeper kind of technical and professional engagement could have been consistently possible.

In view of the fact that at important points it appeared that USAID/Philippines was not giving enough attention to negative indications issuing from the family planning program (see earlier discussion, "Data for Management and Research"), it was concluded that it is possible that Mission technical backstopping was thin at those same points. Unfortunately, data were not available to permit CDIE to verify such concurrence.

Appendix A

The Catholic Church and Family Planning

No impact assessment of the family planning program in the Philippines would be complete without a brief discussion of the role of the Catholic Church. In fact, in recent years, the legitimacy, direction, and overall performance of the

profoundly affected by the Church. The purpose of this
ıss (1) the Church's historical response to state-sponsored family planning activities, (2) its role in shaping current public policies and program, and (3) its influence on reproductive choice of the laity.

The Church's Response to Family Planning During the Marcos Regime

Historically, the Church in the Philippines has faithfully adhered to the Vatican's position on family, sex, and planned parenthood as enunciated in the encyclical *Humanae Vitae* issued by the Vatican in July 1968. The essential elements of its position are as follows: (1) the primary purpose of sex is to procreate, although sex between spouses for other purposes is not totally forbidden; (2) abortion, sterilization, and contraception are intrinsically wrong and should not be used by Catholics, nor promoted by the Government and public bodies; and (3) natural family planning methods are the only legitimate methods for planned parenthood. While the Church leadership recognizes that rapid population growth in the country may not be conducive to economic growth, it is also convinced that modern family planning methods are inconsistent with the teachings of Catholicism. The Philippine Church hierarchy enthusiastically endorsed *Humanae Vitae* when it was issued by the Pope.

Despite its stated reservations about family planning, the Church hierarchy participated in the Population Commission (POPCOM), which was established in 1969 by President Marcos to formulate population policy and lead the national program. Although Church representatives recognized the importance of collaboration among the "responsible sectors of the society," they argued that fertility control is best left in the hands of private groups, and the role of the Government should be simply supportive. They also stressed the importance of natural family planning methods.

After 2 years of collaboration, Church representatives resigned from POPCOM in 1971, signaling a break with the Government on family planning. They disassociated themselves from POPCOM because they felt their presence was used by field-workers to support the claim that the Church approved all contraceptive methods.

In 1973, the Church issued a pastoral letter criticizing the Government's bias for promoting pills and IUDs. Later, in another letter that was subtitled, "Thou shalt not kill," Cardinal Sin expounded the rights of the unborn child. It appears that the Church hierarchy strongly believed—and continues to believe—that the availability of contraceptives has been undermining the morals of Catholic populations and will ultimately pave the way for the legalization of abortion. As Desiderio (1991) explains it, "A strong undercurrent to Church opposition was the hierarchy's apprehension that promoting artificial birth control would lead to surgical sterilization and the acceptability of abortion."

On the whole, the Church's opposition to the family planning program was relatively muted during the 1970s when martial law was in effect. But when Church leaders protested on a specific topic, Government officials privately met with them and tried to alleviate their concerns. For example, in 1976 the Population Center Foundation launched a social marketing project that involved the marketing of condoms by supermarkets. The open display of condoms in supermarkets offended the Church. The Government immediately relented and terminated the project.

As documented in the main report, significant progress in fertility reduction was made during the 1970s; however, the momentum was arrested as the political legitimacy of Marcos's rule eroded in the early 1980s. The Church intensified its attacks on the family planning program, perhaps reflecting the strong antifamily planning position taken by the Vatican. The Marcos Government was too preoccupied with the worsening political and economic crisis to defend the program against the Church's onslaughts.

The Church's Impact on the Population Policy of the Aquino Government

During the early years of the Aquino presidency, the Church hierarchy enjoyed unprecedented political influence and authority, which it successfully used to undermine the family planning program. The Church scored two major victories: the deletion of the population control mandate in the 1973 Constitution,

which gave the Government responsibility "to achieve and maintain population levels most conducive to the national welfare" (Article XV, Section 12), and the insertion of a clause to "equally protect the life of the mother and the life of the unborn from conception" (Article 11, Section 12) (Desiderio 1991). These changes have undoubtedly weakened the political and ethical legitimacy of family planning efforts in the country.

The Church has also been successful in silencing legislators who do not agree with it, but are afraid that the expression of their views will bring them in direct opposition to the Church and will adversely affect their election prospects. Moreover, to obtain Church support, many legislators have sponsored resolutions that draw attention to the dangers of artificial contraceptives, particularly the use of IUDs and an injectable drug, Depo-Provera. To counteract antifamily planning propaganda among the legislators, an advocacy group has been formed in the Congress to mobilize support for family planning.

The staunchly Catholic conservatives in the Government, particularly those belonging to Opus Dei, have sabotaged the program from within. It has been reported that one Opus Dei member, as head of the National Economic and Development Authority (NEDA), succeeded in eliminating demographic targets from the national development plans and even delayed payment of salaries for family planning workers. Another member, who assumed the chairmanship of POPCOM, was thought to have used its funds to finance pro-life interest groups. Cases such as these have been reported in the Philippine press.

Box A-1 gives excerpts from comments made by officials and experts in interviews.

Since 1990, Government officials have initiated contacts with the Church to discuss the new strategy and directions of the family planning program. A major event was a meeting between senior Government of the Philippines officials and representatives of the Catholic Bishops Conference held August 14, 1990. At the end of this meeting, a joint statement was issued that emphasized individual freedom and integration of the program with maternal and child health care, and the availability of medically safe methods to interested individuals and couples. However, after the joint statement was issued, the Conference leadership repudiated it.

Later in the week, the Bishops' Committee on Marriage and Family Life issued a pastoral letter strongly condemning all artificial contraceptive methods

Box A-1. Experts' Comments on the Role of the Catholic Church in Family Planning in the Philippines

"The Church's influence on policy formulation and implementation in the present Government is paramount. Cory Aquino feels personally indebted to Cardinal Sin for bringing her into power. The last thing that she will do is to offend him by supporting a strong family planning program."

- a population expert

"There is no doubt that the Church destroyed the whole program. It does not have to tell them [Government officials] what to do, they already know what it wants. Some officials have been trying to revive the program, but only within a framework that is acceptable to the Church."

- a family planning leader

"Every elected politician is afraid of the Church. The fear is unnecessary because the Church does not have great influence on voters, but it does exist."

- the executive director of an NGO

"They [the Church] criticize us, but we cannot respond. After all, they have newspapers and radios."

- a senior Government official

"The problem is not with the people, but with the political leaders, cabinet members, and legislators who, under the influence of the Church, are destroying the program."

- a family planning worker

"Opus Dei is more powerful in the Government than is recognized. Perhaps it is powerful because its membership is confident. They [the members] have stifled the program in the past and they may do it again."

— a Filipino population expert

and advised Government officials, doctors, political leaders, family planning workers, priests, and laity against participating in family planning activities, except natural methods. At the protests of several progressive bishops who were members of the committee but were not consulted, the letter was later rescinded.

Formal and informal contacts between Church leaders and the Government of the Philippines have started bearing fruit. Although the Church is not likely to change its position, it has already toned down its criticism.

Impact on Reproductive Choice

It is difficult to assess the effects of the Church's pronouncements on fertility decisions of the Catholic population. One would intuitively assume that given the dominance of the Church, men and women are influenced by it. Through their sermons and counseling, priests do shape people's attitudes and behavior patterns concerning family, sex, and lifestyles, especially in the villages and small towns. While there is some substance to this assumption, both empirical and anecdotal evidence suggests that the Church's influence on reproductive choice has not been as preponderant as is often assumed.

For example, in the 1978 Philippine Fertility Survey (Concepcion 1988), Catholic women of all age groups reported relatively higher contraceptive use than all other religions combined. In another study, Bulatao et al. (1989) did not find any correlation between Catholic faith and the reliance on the rhythm method. His data suggested that couples' preferences for particular methods were positively correlated to their "contraceptive goals" or intentions. Another survey conducted at Ateneo de Manila University (1989) found that 84 percent of Filipino adults wanted to have fewer children. Only 29 percent of the adults claimed to be familiar with the Church's position on family planning, and only half of them could articulate it. Around 80 percent expressed satisfaction with the Government family planning program. It may be mentioned here that these findings are consistent with those of surveys and studies undertaken in other Catholic countries.

The team also conducted interviews with a wide range of informants that support the above conclusion. A sample of quotes is given in Box A-2.

That the Church's influence on reproductive choice of couples is only marginal is also evident from other factors. First, the demand for artificial contraceptives has been rising despite the opposition of the Church. Second, the proportion of married women using contraceptive methods has increased from 16 percent in 1968 to 36 percent in 1988. Third, many priests do not share the Church's position and are more flexible on the subject. Quite a few adopt an attitude of indifference, leaving the matter to individual conscience. Finally, the country has high literacy rates and is undergoing rapid modernization.

Box A-2. Influence of the Catholic Church on the Reproductive Choice of Filipinos

"Filipinos are quite independent people and are not very much guided by religious dogmas....The majority of the people follow their individual conscience in such matters."

— a former A.I.D. official

"Filipinos are not different from Catholics in America. I have lived there [the United States]. It is a myth that we are more susceptible to the Church's influence."

— a family planning worker

"You must realize that the Catholic Church is not a monolithic organization. Local priests do not necessarily articulate the views of the Church leadership. Even the bishops are divided on this issue. We should not overestimate its role in family life."

— an NGO official

"I would say that the Church's influence on the fertility choice of women is not significant. In my view, both the impact of the population program and of religion has been overestimated. Fertility decisions are largely affected by education, participation in the labor force, urbanization, industrialization, and, above all, economic conditions—and not by what the Church says."

— a senior Government official

"I have worked for the past 30 years among women—poor women. They do not want large families. They beg for contraceptives, for sterilization. Do they care about the Church? No, they don't! The Church influences the Government and not the people."

— a veteran family planning leader

In conclusion, it can be surmised that while the Church does not carry much weight in influencing the fertility decisions of couples in this predominantly Catholic country, it has been able to influence the national family planning policy and program because of its unique position and influence in the Aquino Government.

Appendix B

Nongovernmental Organizations

Nongovernmental organizations (NGOs) have played a major, decisive role in the family planning program of the Philippines. They were the pioneers in that they started providing family planning services years before the Government recognized the need. Once the Government embarked on a comprehensive family planning program, NGOs became important partners and leaders in it. And during the late 1980s when the whole program was in disarray, NGOs managed to survive and keep the program alive with minimal assistance. In view of the volatile political environment, there is a consensus in private and public circles that the future survival and success of the family planning program is closely tied to the vision, capabilities, and performance of NGOs.

Growth and the Present Status of NGOs

As early as the 1920s, Protestant missionaries began advocating smaller families, but their efforts were on an extremely small scale. They were also constrained by laws that restricted the importation of contraceptive materials. After Philippine independence, the Mary Johnston Hospital in Manila led the way toward family planning by initiating a project that provided motivators with clinical support and contraceptive supplies. The Philippine Federation of Christian Churches (now the National Council of Churches in the Philippines) also opened a family planning clinic in Manila in 1957. Gradually, many hospitals and clinics started offering family planning services, culminating in the establishment of the Family Planning Association of the Philippines in 1965.

The establishment of the Philippines Population Commission (POPCOM) as a line agency in 1970 contributed to the rapid expansion of existing NGOs and the growth of new ones. There is currently a strong community of NGOs, but estimates about its size range from 15 to 545, depending on the purpose of the inquiry. In this evaluation, we have primarily examined national level organizations that mainly, though not exclusively, focus on family planning activities. These NGOs usually perform a variety of functions, such as the delivery of clinical services, training of professional and managerial staff, and the conduct of information, education, and communication (IEC), and have affiliated clinics and

groups in different divisions of the country. Box B-1 gives a brief description of one of the NGOs, Family Planning Organization of the Philippines (FPOP). Other NGOs that have played a significant role are Institute of Maternal and Child Health (IMCH), Integrated Maternal Child Care Services and Development Incorporated (IMCCSDI), and the Philippine Center for Population Development.

Box B-1. The Family Planning Organization of the Philippines

The Family Planning Organization of the Philippines (FPOP) is a leading NGO, promoting family planning and planned parenthood. Established in 1969, it is affiliated with the International Planned Parenthood Federation. It has 26 chapters (volunteer-organized units) in 26 provinces, with over 1,156 chapter-based volunteers and 296 professional staff.

The organization has a network of 26 main clinics, 55 subclinics, 120 mobile sterilization centers, and over 1,000 trained community-based distributors of contraceptives. Clinics provide a comprehensive package of family planning services, including voluntary surgical sterilization (tubal ligation and vasectomy) and reversible contraceptive methods that include natural family planning. FPOP also provides medical backup and laboratory services to its clients.

FPOP carries out a three-pronged approach of public information, family planning advocacy, and community education and motivation. Public information and advocacy efforts are directed toward policymakers, opinion leaders, religious and community leaders, professionals, and mass media. Community education and motivation efforts, on the other hand, are designed to target married couples of reproductive age (15 to 45 years), young adults (21 to 25 years) who are on the threshold of marriage, and adolescents in the 15 to 21 years age bracket. FPOP also supports programs for women and youth welfare.

USAID/Manila has consistently supported NGOs since the late 1960s, when it funded IMCH, Asian Social Institute, FPOP, and the Planned Parenthood Movement in the Philippines. USAID/Manila's support in the formative years of these NGOs was critical to their growth. Later A.I.D. funds were channelled through POPCOM, and as a result the Mission's direct involvement with NGOs became

limited. Under a newly signed project, USAID/Manila will again be able to fund NGOs directly through a contract with John Snow, Inc.

Major Contributions and Achievements

Over the past two decades, NGOs have made major contributions to family planning, which are widely recognized; however, three deserve special mention.

First, as noted earlier, NGOs were pioneers in family planning in the Philippines. They introduced the concept to the country and set up the initial model for service delivery, which was adopted by the Government. More important, because of their administrative flexibility and freedom from direct political interference, they were able to experiment with many new approaches, strategies, and contraceptive methods. For example, they pioneered the use of surgical contraception. Similarly, religious NGOs were the first to introduce natural family planning methods, presently offered as a part of the "cafeteria approach." NGOs were also responsible for initiating adolescent fertility management projects that focus on sex education. However, it should be recognized that NGOs could afford to be innovative, mainly because of the generous financial and moral support of the Government and international donor agencies.

Second, NGOs contributed to the rapid expansion of clinical services. The data show that they have operated nearly 15 percent of the family planning clinics. The three NGOs that had the largest number of affiliated clinics are IMCH, IMCCSDI, and FPOP. Judging by the number of new acceptors, their contribution has been quite significant. As Table B-1 indicates, NGOs were re-

Table B-1. Contraceptive Acceptors Served by Government and NGO Clinics, 1986-1989

Year	Number of Government Acceptors	Number of NGO Acceptors	Total Acceptors	Government Acceptors (percentage of totals)	NGO Acceptors (percentage of totals)
1986	363,968	145,322	509,290	71.5	28.5
1987	454,719	101,864	556,583	81.7	18.3
1988	392,428	132,193	524,621	74.0	26.0
1989	399,202	77,911	477,113	83.7	16.3

sponsible for 145,322 new acceptors in 1986, 101,864 in 1987, and 132,193 in 1988. The organizations did not perform as well in 1989, when the absence of Government funds created severe financial problems.

Three factors can explain this phenomenon. One, while Government clinics provided family planning services only one day a week, NGO clinics were open all week. Two, NGO clinics primarily operated in urban and semiurban areas where population density is relatively high. Government clinics were also located in rural areas. Thus on average, the catchment area for NGO clinics is likely to be larger. Three, NGO staff were often more qualified.

Many health professionals believe that NGO clinics offered superior services to their clients. As compared with Government clinics, the NGO staff were thought to be better qualified and more caring. Moreover, they were better equipped with supplies. Although there is no hard empirical evidence supporting this widely held impression, it looks intuitively sound. At the least, it is consistent with the experience of public bureaucracies around the world.

Third, NGOs have helped the Government build a vast "institutional infrastructure" for family planning. A few general observations can be made in this connection.

NGOs were heavily involved in massive training undertaken under the auspices of the family planning program. POPCOM estimates that between 1970 and 1989, 425,362 people—doctors, nurses, midwives, health professionals, management staff, outreach workers, and IEC personnel—were trained in the country. At least half of them were trained by NGOs. However, these figures should not be taken at face value. Often the same people were trained again and again. Moreover, trained personnel did not always stay in the family planning sector. But even if allowance is made for these problems, the importance of such training both in the performance and sustainability of the program can hardly be overemphasized.

Table B-2 gives some information about the type of training provided by the Government and NGOs. It shows that NGOs accounted for more than one-half of trainees.

The vast network of clinics and centers affiliated with NGOs constitutes another element of the institutional infrastructure. At present, some of these clinics and centers are not active because of funding problems, but they can be easily reactivated once the required funds are forthcoming. The evaluation team met with doctors, nurses, and professionals connected with such clinics and

Table B-2. Types of Training Provided and Number of Family Planning Personnel Trained by NGOs and Government Organizations, 1978-1987

Type of Training	Number of Personnel Trained	
	NGOs	Government Organizations
Service Delivery	233	257
Information, Education, Communication	185	20
Management	70	111
Total	488	388

centers and was impressed by their commitment and expertise. They undoubtedly constitute an immense resource for the program.

The last element in the social infrastructure is the local chapters, centers, and informal groups formed by or affiliated with the national NGOs. Such groups disseminate information about family planning and help in mobilizing public opinion for it.

Box B-2 gives a few excerpts from key informant interviews conducted by the evaluation team on the contribution and strengths of NGOs.

Limitations and Potential

Despite their significant achievements, NGOs have suffered from several limitations that have prevented them from using their full potential and that pose a threat to their long-term sustainability.

First, the management of NGOs has been generally weak. During their formative years, most of them were led by charismatic individuals who were not necessarily good managers. Often these leaders were medical professionals who had neither the skills nor interest in modern management practices. Consequently, they ignored issues concerning long-term planning, economic efficiency, performance monitoring, and evaluation of results.

For example, an overwhelming majority of NGOs still do not have functional monitoring and evaluation systems. The only monitoring data they gathered were

Box B-2. Comments of Key Informants Concerning the Strengths and Contributions of NGOs Involved in Family Planning

"We were the number one, the pioneer in family planning. We initiated it. The Government followed us."

— an NGO leader

"NGOs were showing the way, and the Department of Health was following them. This was at least the case in the beginning."

— a former executive director of POPCOM

"A partnership existed between the Government and NGOs. We [Government] always saw them as efficient partners who had flexibility and commitment. POPCOM was very much committed to their growth. We did not see them as competitors."

— a senior Government official

"The quality of the training offered [by NGOs] is much better than [that] provided by the Government. I served in the Government for 30 years and I say it on the basis of my own experience."

— an NGO staffer

"The clinics affiliated with the NGOs generally perform better than Government clinics. They have better staff and resources, and they work the whole week. Government clinics are generally overburdened."

— a population expert

the listings of contraceptive users, dropouts, and new acceptors. Often these categories had serious definitional problems. For example, if a woman gave up using the rhythm method and started taking pills, she would be classified as a new acceptor. In the same vein, if she moved to a different city and joined another clinic, she would be considered a dropout in the first but a new acceptor in the second clinic. A still more serious problem with the NGO system was the limited focus on the evaluation of technical services, rather than on evaluation of the whole project to determine its efficiency and effectiveness.

Box B-3. Sources of Funding for the Family Planning Organization of the Philippines

As an affiliate of the International Planned Parenthood Federation (IPPF), FPOP has been receiving grants since its inception from the parent institution. The most recent data show that it has been able to raise less than 20 percent of its budget from fees, donations, trust funds, and memberships.

Sources of Funds (in million pesos)	Year	
	1989	1990
IPPF	16.4	16.9
Other donors	7.2	20.2
Local	4.9	8.2
Total	28.5	45.3

Note: It should be recognized, however, that FPOP is much ahead of other NGOs, because as an affiliate of IPPF, it must charge fees for its services. Therefore, it was better able than others to provide services when Government funds were not available.

A second, and undoubtedly equally important, limitation is that NGOs have been dependent on outside funding and have made minimal efforts to generate funds from their own activities (see Box B-3 for an example of funding sources for FPOP). One obvious reason is that, in the past, well-established NGOs operated in an environment of abundant resources made available to them by the Government and international donor agencies. Consequently, they did not appreciate the need to raise their own resources. Thus, until recently, most of them did not charge even a token fee for their services or seek donations from clients. Part of the blame for this situation rests with A.I.D., which insisted that NGOs could not charge for the free commodities supplied to them. But later, when A.I.D. changed its policy, NGOs did not show much enthusiasm. They generally pressed for a greater subsidy and resisted imposing fees on the grounds that it would deter new acceptors and current users. Only recently have they started charging modest fees or taking donations.

Third, no systematic attempts were made to clearly demarcate the catchment areas between NGOs and Government clinics, and among NGO clinics. Both NGO and Government clinics operated in the same areas, and, in a few instances, in adjoining buildings. Moreover, they usually catered to the same categories of

clients. If they were charging fees, such healthy competition between the NGOs and Government clinics would have improved their efficiency. But since they did not, it resulted in unnecessary waste.

Box B-4 gives a few comments made by Philippine NGO representatives, experts, and Government officials on the shortcomings of NGOs and their future potential.

Box B-4. Comments by Key Informants on Limitations and Future Potential of Nongovernmental Organizations

"I agree that NGOs were spoiled in the past. We were never short of resources. Both the Government and donors were very generous. Therefore, we did not try to raise our own funds."

— president of an NGO

"There was no evaluation of the project at its termination. The projects were renewed automatically. Therefore, NGOs had not to bother about costs and costs sharing."

— executive director of an NGO

"We have started looking at ourselves. We do not want to depend on external resources. We have to empower the people. I am a medical doctor. I don't take any salary from it (NGO). And I am sure that we can stand on our own feet."

— physician working in an NGO

"They have ideals, but lack management and financial skills."

— a university professor

"The Government cannot implement our family planning program without NGOs. Our plans seek to serve 6.5 million new acceptors, and the NGO sector is expected to contribute 35 percent or 2.3 million new acceptors."

— a senior Government official

"In the present uncertain environment, NGOs and the local governments are our only hopes. And out of these two, I am more hopeful about the NGOs. They have commitment, skills, and grassroots networks."

— a USAID staff member

However, there are signs that NGOs are becoming aware of these deficiencies and have been taking steps to improve themselves. They have become more sensitive to the issues of cost sharing and have started charging token fees. Some are also focusing on instituting modern management. In a few NGOs the team visited, a younger generation of trained managers seems to be assuming increasing responsibilities. A growing consciousness exists among the NGO leadership that they have become self-reliant and have shed the subculture of donor dependence. All this seems to augur well for the future.

Appendix C

Evaluation Team Comments Concerning Performance on Items of the Lapham-Mauldin Scale

Policy and Stage Setting

 population policy development in the Philippines has been land, where it took a 7-year debate to reach consensus on a policy, the early years of policy development in the Philippines were remarkably smooth; President Marcos issued a decree which was first confirmed legislatively and then made part of the 1973 Constitution. This relatively easy establishment of a policy with demographic targets misled the leadership, which exerted little proactive effort to develop in-depth policy support from various constituencies throughout the country. One exception, the Outreach program, operated by the Population Commission (POPCOM), attempted in 73 local government units to gain the support of every governor. Even this POPCOM effort was undertaken more as a means of securing fiscal than political or philosophical support.

With the growth of the family planning program, especially the popularity of voluntary surgical contraception (VSC), the Catholic Church expressed objections. As early as 1978, a strong portent for revising program goals and policy came when President Marcos accepted the Report of the Special Committee to Review the Philippine Population Program. Its major recommendation was that the program shift its emphasis from fertility reduction to family welfare. Two years later, POPCOM responded by issuing its Medium Term Plan (1981-1985), which largely ignored the key recommendations of the Special Committee and the President.

During the ensuing years, any real efforts to mobilize broad-based support for population policies were shelved while POPCOM and its Board tried unsuccessfully to develop enough internal consensus to operate the program and to deal with the international donors.

One indicator of the failure to develop policy support for the program can be seen in the declining percentage of national budget devoted to population expenditures. In the 1970s, the budget for the national population program averaged

0.7 percent, but this fell to an average of 0.3 percent in the 1980s, at a time when many other Asian countries were increasing the percentage of total budget devoted to population.

From 1970-1988, the Government's contribution covered only 42 percent of population program costs. In 1980, the Government attained its highest contribution of 66.5 percent to the program. According to Lapham and Mauldin, highest marks for strong policy support go to countries with 85 percent of resources coming from in-country sources; countries providing less than 50 percent to their programs receive a 0 score.

On other policy elements, the Government's record has been mixed. In the early years of the program, the president, his wife, and other high-level leaders spoke of the dangers of rapid population growth. The 1973 Constitution stated that, "It shall be the responsibility of the state to achieve and maintain population levels most conducive to the nation's welfare." Although such a strong statement favoring population programs would be judged as a policy plus by most of the population community, many Filipinos might have associated the policy statement with the increasingly repressive Marcos regime. President Aquino, on the other hand, has been more restrained in her public statements of support for population.

Philippine policy performance on other Lapham-Mauldin (L-M) items was also mixed. For example, from its inception, the Philippine program involved many ministries (later departments), most notably health, education, and labor. Import duties on contraceptives were waived until recently. Although there is no official age of marriage, this is not a policy lacuna since the average age of marriage for both sexes during these years exceeded 22 and currently is 24.4—well above the world average. On the less positive side, no efforts were made to involve the commercial or social marketing sectors, and advertising of contraceptives on television, while not banned by law, was not pursued because of perceived cultural sensitivities and likely opposition from the Catholic Church.

Although the Philippine program had many policy pluses going for it, especially during the formative years, the absence of a meaningful role for the commercial sector, coupled with low fiscal inputs from the Government, largely negated the positive policy measures undertaken by the latter. As recently as 1990, the Government itself rated program achievements as "modest and limited" and cited lack of political support as the number one cause. The second reason given by the Government for modest achievement levels was discontinuities in

POPCOM Board and Secretariat leadership, an obvious by-product of uneven political support.

With the change of government in 1986, family planning proponents in the public and private sectors were attacked in the media, from the pulpit, and in the halls of the Philippine Congress. While a few took up the new line of natural family planning, most bided their time until the Philippine NGO Council on Population, Health and Welfare was launched in 1987. This provided a forum for the examination and discussion of population issues and an institutional base for dealing with national Government officials, testifying before the Congress, meeting with governors, and similar activities.

A very successful effort to build a wide base of policy support has been carried out by a private foundation, the Philippine Legislators' Committee on Population and Development, established under the leadership of Senator Leticia Ramos-Shahani in 1987. The Committee is housed in an office next to the Office of the Speaker of the House, where Committee staff is well situated for dialogue. Financial support for the Committee was provided through PP III. The United Nations has made funds available to the Committee, and the Futures Group has been providing technical assistance for organizing regional workshops involving governors, mayors, and congressional and community leaders in policy discussions on the developmental implications of rapid population growth on such matters as the environment, nutrition, health, and the status of women.

While the Catholic Church admits there is a population problem, it disagrees that artificial contraception is a legitimate means of addressing this problem. The hierarchy of the Church has especially apposed sterilization, believing that if VSC is widely accepted, abortion would be harder to resist (Family Health Care, Inc. 1977, 64). President Aquino has, without endorsing modern contraceptives, issued statements and taken other positive actions to enable married couples to make family-size choices and for Government and private entities to explore and disseminate information about the developmental consequences of rapid population growth. In addition to moving POPCOM under the National Education and Development Authority (NEDA) (the president is chairman of the NEDA Board) away from the Department of Social Welfare and Development where it was completely hamstrung, President Aquino said in her 1987 May Day speech, "Of course, we have to assure that our population growth does not outstrip our other resources and whatever gains we make every year." Moreover, the 1987-1992 Development Plan, which calls for a reduced population growth rate aligned with a replacement fertility level by 2010, is a major commitment by the Aquino

Government. Probably the most forthright support from the president came in her State of the Nation Address before the two houses of the Philippine Congress on July 24, 1989, when she said

> As we emerge from a singular preoccupation with economic recovery, we must remind ourselves of initiatives that will have a major impact now and profound implications tomorrow. Three particular priorities are: the protection of the environment, the promotion of family planning and responsible parenthood, and the development of science and technology.

While perhaps not in a perfect policy environment, the program now has sufficient latitude for governmental agencies and NGOs to seize the initiative. Moreover, the residual goodwill engendered outside the national capital area during the Outreach years provides a base for rapid resumption of the service program. Although badly battered during the lean years, the NGOs under the NGO Council leadership are learning the dual lesson of group solidarity and self-reliance. Finally, the Legislators' Committee has established itself as a constructive advocate with the legislature. Now that policymakers have reached sufficient consensus to allow the program to reactivate, acceptors have responded encouragingly; Department of Health new acceptors increased from 179,603 in 1984 to 539,018 in 1989. Likewise, in the private sector at the International Planned Parenthood Federation (IPPF) affiliate, male and female surgical contraception jumped from 5,197 in 1988 to 13,758 in 1990. In the commercial sector, the numbers are not so precise, but sales trends followed similar patterns.

Service and Service-Related Activities

Involvement of Private-Sector Agencies. To a lesser extent than in Latin America, but more than in most other Asian countries, the private (noncommercial) sector has been significantly involved in family planning efforts in the Philippines. In recognition of the key role that NGOs have played, the Government reserved three places for the private sector on the POPCOM Board. The Department of Health also recognized the fact that at least one-third of the contraceptive clinic load has been handled by the NGOs. This aspect of the program therefore gets high marks on the L-M Scale. (See also Appendix B on NGOs.)

Civil Bureaucracy Used. The L-M score for the use of the civil bureaucracy is one of the lowest reported for 1989, principally because the program wanted to ensure that program directions were carried out, and senior officials below the Federal level did not feel responsible for the success of the program. The team

nevertheless notes that from the inception of the population program, the Government involved some 12 ministries (departments) in some way in family planning, especially health, education, labor, and the military at the national level.

Community-Based Distribution. The Philippine program mobilized one of the largest community-based distribution (CBD) programs (Outreach) ever undertaken, thus achieving a remarkable access level of one service point for every 99 married women of reproductive age. As a result, more than 30 percent of users obtained their supplies from Outreach. *In fact, a major reason for the adoption of the Outreach program was the realization that its predecessor, the static, clinic-based system, was not reaching a large enough proportion of the target group.* Thus, in terms of access and affordability to the user, the Philippine CBD program deserves very high marks; far higher, for example, than Indonesia, where only 19 percent of acceptors were supplied through Outreach, or Thailand, where CBD reached only 10 percent. Unfortunately, the contraceptive training aspect of the distribution effort was weak. Moreover, while Outreach was administratively and culturally doable, it was not fiscally sustainable as designed. Because of inadequate training and an insecure fiscal base, the massive distribution program in the Philippines rates only a middle grade on the L-M Scale.

Social Marketing. One of the major failures of the Philippine program—until very recently—was its total rejection of social marketing. Social marketing and advertising of contraceptives was one area in which the views of the Church held sway in POPCOM. However, the revitalized program under Department of Health leadership is planning a major role for social marketing. The department will be starting from a surprisingly strong position in that nearly one-third of oral contraceptives used in the Philippines are already being purchased through the commercial sector, even without the benefit of advertising.

Postpartum Programs. The record in this field was generally positive. The majority of VSC procedures were postpartum, with the age of women averaging 30 years, and with parity just below four, which is the same as the current total fertility rate. A surprising 62 percent of VSC acceptors had never previously used contraception. The Philippine postpartum IUD program had limited success, but the Philippine effort should not be singled out, since success in this area is very rare. Because of the adverse effect on the quality of breast milk, most pills are not medically appropriate immediately postpartum.

Home-Visiting Workers. The Community Outreach Survey data indicated that barangay supply point officers and the full-time Outreach workers who did

home visits to motivate clients were more effective than those who did not, and that home visits were very important in determining the level of prevalence. If each worker conducted eight home visits per week, about one-fourth of the married couples of reproductive age in their area would be covered. However, of the wives interviewed in the Outreach survey, all of whom lived in Outreach areas, only 11 percent said the workers had discussed family planning with them in the year preceding the interview. A little over one-half of the supply point officers interviewed said they had done no home visits during the month preceding the interview. Overall, this was very inadequate performance.

Administrative Structure. In setting up their population program, the Government leadership recognized that the problem was multidimensional. POPCOM was intentionally designed with representation from 12 ministries, the private sector, and, initially, the Church. It was POPCOM's responsibility to develop policy and to coordinate family activities largely through Department of Health and NGO clinics. However, with the start of Outreach in 1976, POPCOM became operational, with direct responsibility for Outreach activities. POPCOM developed its own training unit, along with increased administrative staff at headquarters and in its 13 regional offices. Consequently, POPCOM's administrative costs increased from 2.4 percent in 1973 to 29.6 percent in 1986.

Almost as serious as the rise in administrative costs was the loss of the unity of command principle of organizational efficiency, which occurred when POPCOM retained technical direction of the Outreach staff, who were otherwise under the administrative control of the local government units. To compound the lack of unified command, Outreach commodities and training emanated from POPCOM whereas referrals had to be made to Department of Health clinics.

While the Philippines can be admired for the boldness of its vision in designing a nationwide delivery system, the structure was administratively flawed and costly.

Training. An important feature of the Philippine program was the large number of personnel trained. From 1969 through 1989, family planning training was provided to the following categories:

Clinical	24,907	
IEC	155,698	(includes school teachers)
Management	74,942	
Outreach	165,815	
Total	421,362	

Much of the training was short term and many people were trained under more than one category; thus, there has been double counting in all categories. Except for Outreach, the vast majority of the training occurred before 1979.

Under the Outreach program, a national network was developed which recruited and trained people from all parts of the country (most of whom remained committed to population planning as a key element in development and family planning as an important part of health care).

All sources agree that budget limitations greatly reduced training efforts in the latter years of the program. Still, the number of people trained through the NGOs, the Department of Health, the Department of Education, and POPCOM is remarkable, especially when one considers that only 5.5 percent of the population budget was devoted to training between 1973 and 1988. In addition to the doctors, nurses, and midwives trained in family planning skills, the Philippines trained 2.6 times as many Outreach workers as Indonesia with its much larger population. By 1987, the Philippines had one service outlet for every 16,474 people, versus Indonesia's one service point for 20,810 persons. In addition the program had a resupply point for every 99 married woman of reproductive age—one of the best records in the world.

Moreover, the Philippines trained top-flight surgical contraceptive specialty teams. This cadre of trainees is almost unknown in Indonesia with its low VSC acceptance rate (6.9 versus 30.5 for the Philippines in 1988). The Philippine VSC training teams were so outstanding that A.I.D. and other donors sent them to train local VSC teams in other Asian and African countries: for example, Bangladesh, Burma, Fiji, Indonesia, Malaysia, Nepal, Nigeria, Pakistan, New Guinea, Sri Lanka, and Thailand. This second generation multiplier effect on other developing countries of A.I.D.'s investment in the Philippines is often overlooked.

How many of the total trained personnel are available to the current program? One very high-level Department of Health authority insisted that due to attrition and emigration, 80 percent of the trained doctors, nurses, and midwives are gone. Another Department of Health leader, however, provided a more hopeful picture, saying that 52 percent of Department of Health doctors, nurses, and midwives had received basic family planning training and would therefore require only refresher training and IUD insertion skills. A 1988 United Nations Population Fund study of current family planning workers showed that only 40 percent of physicians and nurses and 53 percent of midwives had taken courses in family planning. Eighty percent of all workers said they wanted more training.

On the L-M Scale, the training component has the second highest score (3.33) in service and service-related activities for 1989, because great numbers of people were trained and subsequently well received in their communities. However, beyond the sheer numbers of trainees, there were quality problems: many of the trainees were not trained sufficiently in contraception skills, many supervisors were not trained in management skills, and most clinical staff were not given preservice training.

In sum, the major flaw of POPCOM training was failure to make sure that trainees comprehended the important health benefits of selecting the most effective methods. The next most serious flaw was the failure over the 20-year period to establish preservice family planning training for students of nursing, midwifery, and medicine, at least in the non-Catholic schools of medicine. Finally, management training for senior and midlevel administrators was long neglected.

Personnel To Carry Out Assigned Tasks. For most years, this program aspect would receive a good ranking on the L-M Scale, despite upper-level staff cuts in POPCOM headquarters and the emigration of Filipino nurses in the later years of the program.

Logistics. Judging from assessments and interviews, logistics, including contraceptives, was an effective part of the Philippine program until 1988, when the program was transferred to the Department of Health. By that time, however, the logistics component was already in some distress, because with POPCOM's failure to request support from A.I.D., the contraceptives pipeline was being exhausted throughout the system. Even the supply of IUDs ran out. Moreover, after new contraceptives arrived at customs, POPCOM, in its new nonfamily planning role, failed to process the waiver for import duties. The situation regarding duties has not been resolved, and it will be many months before the logistics system is fully functional again.

The logistics system operated by POPCOM was characterized by many observers as one of "well-managed abundance." Much of that system remains in place, mostly in the regional offices of POPCOM. The logistics and commodities system built by POPCOM with strong A.I.D. support is a sustainable one, provided the Department of Health and POPCOM agree on how to use it. However, it could be further improved by having a more responsive management information system (MIS), as discussed below.

Supervision. Where training is weak, supervision must be correspondingly strong. Unfortunately, as noted earlier, POPCOM's relationship with Outreach

and the Department of Health did not lend itself to the classic unity of command principle; thus medical supervision was not always harmonious and was often entirely missing. This anomaly, coupled with POPCOM's high administrative costs, gives this key element a low ranking on the L-M Scale.

Information, Education, and Communication. Years before the Government of the Philippines recognized the importance of information, education, and communication (IEC) to policy- and program-goal attainment, the NGO community was deeply involved in promoting family planning concepts. The NGOs continued that role through a contract with the Institute for Maternal and Child Health (IMCH) to provide 12 IEC teams in the regions. By 1975, POPCOM had launched its own IEC program. The major successes of the NGO/POPCOM IEC efforts were the enunciation of a national population policy by the Congress in 1971, and the spread of awareness of the concept of family planning to 97 percent of married couples of reproductive age.

However, the IEC program failed in two major respects. The first was in closing the gap between knowledge and action; that is, those with knowledge of family planning did not take advantage of it. Between 30 and 35 percent of those who, for health or personal reasons, wanted to space or limit reproduction did not avail themselves of the services. Secondly, along with service providers, the IEC efforts failed to inform new acceptors of the health and economic benefits of selecting and continuing with effective contraceptive methods. These two flaws in the Philippine IEC program, especially the second one, contributed heavily to the lower effectiveness of the Philippine program compared with other countries of its region, as illustrated in Table C-1.

Table C-1. Acceptors' Choice of Contraceptive Method: Percentage Selecting for the Philippines and Other Countries of Its Region

Country	Choice of Method	1976	1987
Indonesia	Modern	79.9	91.0
	Traditional	20.1	9.0
Philippines	Modern	31.6	57.9
	Traditional	68.4	42.1
Thailand	Modern	33.9	65.5
	Traditional	2.8	2.8

Incentives and Disincentives. The Philippine program offered very limited disincentives (for example, no tax deduction or maternity leave after the fourth child) and no incentives to acceptors. This helps account for the zero score on the L-M Scale, although it should be remembered that many highly successful population programs have been implemented without incentives or disincentives.

Record Keeping, Evaluation, and Research

A weak MIS has been an area of continuing concern for the program since the Outreach expansion was launched. If anything, this situation has deteriorated since 1988. The evaluation components of the Philippine program, accomplished largely through the University of the Philippines Population Institute, can be characterized as of excellent quality, scheduled at regular intervals, but not frequently enough for ongoing management purposes. Thus, high dropout rates, large gaps between knowledge and practice, plus heavy use of ineffective methods, were not discovered as soon as they would have been under a sentinel survey system, a yearly rapid assessment, or with a fully functioning MIS.

Research has received on average nearly 6 percent of the program budget, a percentage that has declined in recent years. More serious than a lack of research funds has been the absence of a research strategy in which the need for answers to specific questions would be the basis for new investigations. The studies that have been conducted have been variously unfocused, uncoordinated, or not brought to the attention of the right people. As early as the 1978 Special Committee Report, attention was drawn to the latter—to failure to undertake what is called "decision research" for the use of policymakers and program managers. For example, although the POPCOM leadership must have been aware of the likely outcome of a program that depended heavily upon the use of ineffective methods, there is no evidence of research on the underlying causes of this fundamental problem. Indeed, almost every assessment or evaluation of the Philippine program has noted this gap in the research component. The demographic and biomedical aspects were, on the contrary, recognized as top flight, although the former could have been improved by more rapid processing of data.

The 1991 World Bank report noted that although much research was done, one would be hard pressed to find any evidence of its being used for management purposes. This conclusion was foreshadowed in the Special Committee Report of 1978, which drew attention to the need for appropriate research on 13 different pages, besides devoting all of chapters 5 and 6 (pages 108-148) to issues in the

research area. It also underscored the need for a research strategy or plan from POPCOM. Two years later, POPCOM responded to these recommendations by merging the research and MIS issues, while offering no comment on the need for a research strategy. POPCOM's total response to the more than 150 pages of the Special Committee Report was given on just one-half of a page of text.

Management Use of Evaluation Findings. Except for the use of 1973 National Demographic Survey results, which stimulated the creation of the Outreach project, POPCOM appears to have ignored key messages which the service statistics and knowledge, attitudes, and practices surveys were sending them. There is no evidence that changes were made in training or IEC to solve the three continuing problems of high drop out rates, knowledge-practice gaps, and choice of ineffective contraceptives. Recently there has been an increase in the use of effective contraceptives, but this appears to be due to users' learning by failure, rather than an improved IEC or revised training.

Availability and Accessibility

Male Sterilization. VSC for males has been offered at no cost in the Philippines. The number of acceptors has been low, but steady. For its courage and persistence in offering these services in a culture hostile to males adopting this form of contraception, the program deserves higher marks than were conferred by the raters who used the L-M Scale.

Female Sterilization. VSC for females has also been available at no cost in the Philippines since the mid-1970s. It grew rapidly and now accounts for 30 percent of national prevalence. In terms of demographic impact, however, the program has not been able to attract acceptors before they have reached an average of parity four (that is, an average of four children). In contrast, parity for Thai VSC acceptors is 2.3.

Condom, Diaphragm, and Spermicide. Of these three methods, only the condom has been available through the Government program. While condoms have been provided at no cost to acceptors, their popularity has declined as a family planning device, due to cultural factors and their high failure rate. The Philippine program wisely decided not to offer diaphragms and spermicides because of their high costs and logistical complexity. The overall rank on Lapham-Mauldin for the Philippine condom program is relatively high.

Pills. Under A.I.D. support, the Philippine program has offered free pills. In terms of absolute number of acceptors, pills have been the contraceptive of choice. This was particularly true during the peak Outreach years. However, because of a high drop out rate and poor use-effectiveness levels in the Philippines, pills have not contributed as much to contraceptive prevalence as VSC for the past 8 years. With female literacy so high, the Government program must be faulted for not improving IEC and training to ameliorate the two problems of high drop out and ineffective methodologies.

IUDs. Along with the high drop out rate for pill users, the most serious flaw in program implementation was the flat acceptance rate for IUDs. Recent surveys have demonstrated that IUDs are the method most desired by Filipino married women of reproductive age. Furthermore, IUDs are the most cost-effective temporary method. Unfortunately, most motivators and service providers have not agreed with acceptors' choice of IUDs, and often led them to less effective methods.

Abortion. Induced abortions are illegal for any reason in the Philippines. Although there have been many stories of increased fetal wastage of late, the team found no solid evidence of a recent increase in induced abortion. The team reviewed materials showing that most women who received postabortion medical care were parity two, and in the age range of 25-34. This would seem to indicate that, for the most part, they were motivated by economic rather than social reasons.

Appendix D

Scores Assigned to Six Factors Derived from the 1990 CDIE Sustainability Study

The succeeding sections discuss the influence of six factors in achieving sustainability in the Philippine family planning program. Each factor is discussed and assigned a score representing the team's summary judgment according to the following six-point scale (Godiksen 1990), which CDIE used in its study of sustainability: Unsustained (0), Minimally sustained (1), Modestly sustained (2), Sustained (3), Well sustained (4), Highly sustained (5).

The Economic Context

The CDIE study of sustainability found that the economic context of the Philippines had more influence on sustainability than did other "contextual factors." In addition to the country report findings considered in the study, in which both the economic context and the political context received the highest ranking of nine contextual factors, CDIE analysts noted the "significant correlation between level of sustainability and level of development across regions."

The overall record of Philippine economic development for the period under study (1968-1988) was uneven. Although the 1970s saw per capita income grow 3.4 percent, the 1980s brought labor force increases of 4.5 percent per year (1980-1987); a doubling of the overall unemployment rate, with urban unemployment reaching 18 percent; a wage decline of about 7 percent in real terms; an increase in the number of people falling below the poverty line; and a per capita gross national product (GNP) decline of 17 percent.

The weaker economy of recent years has meant greater competition for available resources between family planning and other social programs. Perhaps the major effect of this competition was to put pressure on the POPCOM structure, thus increasing the attractiveness of some form of integration with the Department of Health.

With respect to the influence of the economic context on sustainability of the family planning program as of 1988, the situation was bleak. *A score of 2 was assigned for this factor.*

The Political Context and National Commitment

The 1990 CDIE study (Godiksen) showed the political context to be highly related to sustainability. For example, in Thailand, political stability "...has contributed to the steady and sizable momentum achieved in health sector development." In comparing sustainability of programs in Asia, Central America, and Africa, the CDIE study suggested a kind of continuum, pointing out that

> Governmental infrastructure is not as well established in Central America as in Asia, but it is far more developed than in Africa. In Africa, governmental institutions tend to be limited in their management, technical, and budgetary capacities.

National commitment to program goals is defined as consensus among important decision makers and interest groups in the health sector that the goals and objectives of a project or program are a national priority. This factor was crucial to sustainability in the 1990 CDIE study, although experience "...suggests that sustained Government commitment does not guarantee project sustainability."

Between 1968 and 1988 the Philippines moved politically from the "stability" of one-person, one-party rule to a period of deteriorating control to near anarchy, fortunately replaced by the democratic, "people-power" Government of Corazon Aquino. During this interval, political backing for family planning also shifted—from the personal endorsement of the chief of state in the earlier period to a period in which the emphasis on fertility reduction elevated the program to such visibility that the Catholic Church hierarchy openly opposed it, thus fueling a public debate and causing major politicians to avoid open support of fertility control and the focus on contraceptives. When the Government changed hands, and for some time thereafter, a firm family planning policy was not asserted, institutional responsibilities became blurred, internal and external financial support declined, and service delivery suffered.

Performance of the Philippines on the L-M Scale for items reflecting the climate of political support for family planning dropped in the 1980s from a high of 18.20 in 1982 (out of 32 possible points) to 16.16 in 1989; the latter representing only a 50 percent achievement of top performance. Similarly, the political context and national commitment is judged as not having more than an average influence on sustainability by 1988. *A factor score of 3 was assigned.*

Strength of the Implementing Institution and Program Integration

The CDIE sustainability study found that projects least likely to be sustained were those characterized by

> ...weak, fragmented institutions with competing objectives, poor leadership, low skill levels and an unresponsive, overcentralized bureaucracy....foreign donors may inadvertently contribute to this fragmentation by requiring that their project be implemented by a separate unit within [a ministry] and by imposing separate reporting, budgetary, and administrative routines.

Nevertheless, citing examples from Asia, Central America, and Africa, the CDIE study pointed out that

> Although there is continuing support for the relationship between a strong implementing institution and sustainability, it is clear that this factor is not a necessary condition for sustainability. In Senegal and Tanzania, as well as some cases in Central America, projects implemented by weak or stressed ministries of health were also sustained. On the other hand, although projects were sustained they were frequently not very effective.

With respect to program integration, in all six countries of the CDIE sustainability study, researchers found that projects designed and implemented as vertically run, separate hierarchies were less sustained than those that were integrated into the existing institutional hierarchies. The CDIE study states

> Projects are vertically organized if their administrative hierarchy is separate from the usual national implementing agency,...and if this administrative structure has its own narrowly defined goals and objectives....A second aspect of vertical programs is that they tend also to be privileged—they receive salary subsidies and more materials than equivalent services....

The CDIE study notes that donors have encouraged a vertical implementing entity because it enables them to focus resources and activities on program goals and does not require compromises with other interests. However, vertical programs are *vulnerable*: "They have not built up a wide net of administrators who have some interest in continuing the [program's] implementation." It is this core of interest that lobbies for additional domestic resources when donor funding dries up. Further, because vertical programs do frequently rely on external funding and tend to derive their major standing from foreign support, they tend to generate institutional jealousies and "turf conflict" that make them even more

vulnerable and less likely to attract domestic resources when foreign funding ceases.

If there was a single public-sector advocate in the Philippines during most of the period, it was POPCOM. From its founding in 1969, POPCOM was given responsibility for family planning policy and coordination of efforts to implement it. It vigorously promoted its mandate, initially integrating its program with the services of the Department of Health. By 1975, there were approximately 2,500 stationary family planning clinics, although failure to reach more rural segments of the population led to the inauguration in 1976 of the National Population Family Planning Outreach Project.

Policy Framework and Organizational Structure. In the early years, the Philippines family planning program under POPCOM was similar in organization and management to population programs in other countries. POPCOM coordinated policy and the Department of Health was responsible for direct service delivery. This structure changed with the introduction of Outreach, both the largest and the most successful of all population efforts undertaken in the 1968-1988 period.

As the new program was launched, POPCOM gradually pulled away from its collaboration with the Department of Health, in no small part due to the encouragement of A.I.D. and the donor community to establish a separate, vertical delivery system. The Department of Health family planning service staff dropped from 150 in 1976 to fewer than 50 by 1989.

Heavily subsidized by A.I.D., Outreach was a joint effort of POPCOM and local governments, with the former carrying most of the load: coordinating participating public and private nongovernmental organization (NGO) bodies and providing technical assistance, training, IEC, and contraceptive supplies. At its peak in the early 1980s, POPCOM deployed more than 600 provincial, city, and district population officers; 3,000 full-time Outreach workers; and barangay supply point officers for 52,000 villages. At that juncture it was estimated that Outreach was covering about 50 percent of all married couples of reproductive age.

From this high point, POPCOM gradually lost its influence and power. There were several contributing factors. First, by separating from health services delivery and creating a delivery structure parallel to the Department of Health, POPCOM became competitive with the single domestic agency that had the historical responsibility for matters relating to reproductive health. Another effect of

POPCOM's taking over implementation responsibilities was that these functions swamped its policy-coordination function. Third, the visibility of Outreach—as a result of its size and stress on contraceptives—made it increasingly controversial. Fourth, changes in internal leadership in the early 1980s, the transfer of POPCOM from the National Economic and Development Authority to the Ministry of Social Services and Development, and commingling of the POPCOM budget with that of the Ministry served to dilute its power and influence. When national political changes produced a climate of uncertainty about population policy, the quality of the Outreach program went into decline as did POPCOM's institutional reputation and viability. Domestic and external funding were drastically reduced in 1986 and 1987; A.I.D.'s withdrawal of direct support during these latter years reflected the virtual demise of the national family planning program.

In sum, the removal of POPCOM from its position of directing family planning activities meant that institutional sustainability would be dependent on the degree to which personnel, records, and certain functions could be successfully transferred to the Department of Health and integration achieved. In 1988, this was problematic.

The Role of Nongovernmental Organizations and Other Private Sector Entities. In one area of commitment the Philippines has done especially well: gaining the support of a small but very influential private sector for family planning goals—from the 1960s to the present. (See Appendix B for additional information about the role of the private sector.) In fact, several NGOs constituted the sole advocacy force in the Philippines until the Government signed the United Nations Declaration on Population. The first funding made available by A.I.D. for population activities in the late 1960s went to the NGO community; for example, the Institute for Maternal and Child Health, the Asian Social Institute, the Family Planning Association of the Philippines, and the Planned Parenthood Movement in the Philippines.

There is no question that NGOs have been a major *institutional* resource for sustainability of family planning. Apart from NGOs, other nongovernmental delivery channels, such as commercial firms, social marketing, and private practitioners were not integrated into the program. *On this factor, the team assigned a score of 3.*

Program Financing and Expenditures

As noted above, although the family planning program attracted sizable support from sources within and outside the country, it did not develop a sustain-

able financing strategy. From the early 1970s, public financing was channeled through POPCOM. Table D-1 shows sources of expended funds.

Table D-1. Family Planning Expenditures, 1970-1988 (in million pesos, at current prices)

Year	Government	%[a]	External Sources					Total Expenditures
			A.I.D.	%[a]	Others	%[a]	Subtotal	
1970	0.0	-	9.4	74	3.3	26	12.7	12.7
1971	0.0	-	27.4	81	6.4	19	33.8	33.8
1972	8.2	15	39.7	72	7.5	13	47.2	55.4
1973	9.0	15	35.0	57	17.8	18	52.8	61.8
1974	40.4	45	34.5	38	14.7	17	49.2	89.6
1975	32.5	37	41.3	47	14.0	16	55.3	87.8
1976	83.6	53	45.9	29	27.1	18	73.0	156.6
1977	59.6	54	40.2	36	10.2	10	50.4	110.0
1978	69.5	63	34.1	31	6.2	6	40.3	109.8
1979	74.7	62	31.2	26	15.8	12	46.5	121.2
1980	103.4	66	28.9	19	23.1	15	52.0	155.4
1981	124.0	49	87.8	35	40.4	16	128.2	252.2
1982	119.8	53	75.2	33	32.9	14	108.1	227.9
1983	161.0	57	89.0	31	33.8	12	122.8	283.8
1984	147.7	55	71.9	27	49.5	18	121.4	269.1
1985	145.6	51	71.9	25	70.4	24	142.3	287.9
1986	154.6	48	72.4	23	90.6	29	163.0	317.6
1987	108.4	47	86.2	37	35.2	16	121.4	229.8
1988	124.0	55	83.0	37	19.3	8	102.3	226.3
1989	56.0[b]	98	0.0	-	1.2	2	57.2	57.2

Source: adapted from World Bank (1991) data.

Note: FP = family planning

[a]% = percentage of total program funding.

[b]partial figures; the remainder channeled through the Department of Health.

Currency Equivalents: May 1979 - US $1.00 = P7.40
End 1988 - $1.00 = P21.10
End 1989 - $1.00 = P21.70
End 1990 - $1.00 = P28.00

POPCOM and External Funding. Related (World Bank 1991) analysis of family planning financing and expenditures for 1970 to 1988 shows the following:

- Expenditures averaged P179 million annually. Overall, the family planning program accounted for (on average) 5 percent of total public expenditures. By comparison, Bangladesh spent 1 percent, and both Pakistan and Indonesia spent less than 1 percent.
- Although real (constant 1980 prices) total Government expenditures increased by 23 percent between 1983 and 1988, the family planning portion declined steadily after 1984, from 51 percent (close to the 20-year average) to 18 percent in 1988.
- Over the program's first 5 years, real expenditures grew by an average of 4.6 percent annually. From 1976 (when Outreach began) until 1981, average real expenditures grew by almost 18 percent per year.
- Between 1982 and 1986, real expenditures declined by nearly 9 percent annually, and in 1987-1988, the rate of decline exceeded 10 percent. These data are consistent with other evidence cited elsewhere in this report that the Government's policy commitment weakened over the years up to 1986 and was in flux in 1987-1988 while the new policy was being debated. The drop in absolute levels of funding after 1986 also coincides with the slowing rate of fertility decline (if not an increase in fertility) during the late 1980s.
- Government funding, beginning in 1972, accounted for 15 percent of total program expenditure for 2 years, and by 1976 its share had increased to over 50 percent, remaining at or near that level until 1989.
- The Philippine contribution remained less than anticipated under various external funding agreements. In the major A.I.D. project, PP III, the host Government was to provide 70 percent of clinic support services; from 1984 to 1988, the Government's share amounted to barely 40 percent. In a project funded by the International Development Association (IDA), the Philippine expected share was 44 percent of total costs, but only 39 percent was forthcoming.

- External funding, which had supported 85 percent of program expenditures during the first 4 years (of which three-fourths came from A.I.D.) declined by nearly 7 percent in real terms between 1982 and 1986.
- External agencies accounted for nearly 57 percent of total program expenditures between 1970 and 1988. A.I.D. was the principal source (40 percent), followed by UNFPA (7 percent), and the World Bank-IDA (6 percent). Of the other donors, the largest contributions were made by Australia and Japan. In 1987-1988, as major projects came to an end, the flow of external funds through POPCOM declined by 23 percent. These trends have been linked to delays in disbursements resulting from complex Government and donor procedures, devaluation of the peso, and lack of agreement on program milestones, and were associated with A.I.D. deobligations and cancellations of funds from other donors.
- Analysis of real expenditures for family planning by functional category shows that while capital expenditures fluctuated between 1970 and 1987, the average for this period remained relatively high, at 24 percent of the total. However, with the completion of externally funded projects in 1988, the proportion of capital expenditures fell precipitously, reaching less than 3 percent in 1989. As a result, training, research, construction, and the purchase of vehicles and equipment were severely curtailed.
- A.I.D. is estimated to have provided $20 million between 1967 and 1976 for direct support to numerous NGOs and Government agencies, as well as assistance to create POPCOM, and another $15 million between 1977 and 1980 for IEC, training, service delivery, and creation of the Outreach system. After 1980, A.I.D. continued to assist in IEC, family planning services, and Outreach, as well as in demographic measurement, research, and private sector activities through NGOs.
- These A.I.D. efforts were originally scheduled to provide an estimated $56.7 million in combined loan and grant funds over 5 years (1981-1986). The Loan and Grant Agreement was

amended five times over the life of the project, and the completion date extended twice, first to 1987, then to 1988. The loan portion of the project was decreased and the grant portion increased; yet final audited figures show that only $31.9 million was expended, 56 percent of the project obligation.

- In 1985, facing delays in disbursements and difficulties in reaching agreement on new bilateral assistance activities, A.I.D. began to channel funds through centrally funded programs to private sector agencies. This mechanism provided $1.92 million between 1985-1989.

Local Government Support. Although the Philippine family planning program did not elaborate a systematic, longer term plan for self-reliance, in which it would one day exist without external financial support, Outreach did envisage nonfederal monies as playing a major, if not the principal role. The source of this funding was the local government units. Table D-2 shows that from 1981 through 1984, local government units provided P90.5 million, or 43 percent of total Outreach costs of P212 million, and 16 percent of total program costs of P552

Table D-2. Outreach Costs and Total Program Costs for the 1980s With Shares Provided by POPCOM and Local Government Units (in million pesos current)

	Outreach Project Costs			Total Program Costs
	POPCOM	LGUs	Total	
1981	30.9	14.8	45.7	124.0
1982	34.0	18.1	52.1	119.8
1983	32.2	26.0	58.2	161.0
1984	24.2	31.6	55.8	147.7
1985	26.0	46.2	72.2	145.6
1986	13.3	43.7	57.0	154.6
1987	7.7	45.3	53.0	108.4
1988	7.0	43.3	50.3	124.0

Source: World Bank (1991, 47).

Note: LGU = local government unit.

million. From 1985 through 1988, local government units furnished P178 million, or 77 percent of total Outreach costs of P232 million, and 34 percent of total program costs of P533 million.

While total Outreach costs for 1988 were only 10 percent greater than 1981, local government unit contributions had tripled, rising from P14.8 million in 1981 to P43.3 million in 1988. Inflation considerations aside, total program costs fluctuated over the 1980s, returning in 1988 to the same level of P124 million spent in 1981, while the local government unit contribution increased dramatically: in 1981 the local government units' share of total program costs was 12 percent, rising to 35 percent in 1988.

These figures suggest that by 1988 local government units were providing a substantial contribution of about one-third of total program costs. Continued, sustained support beyond this point would depend on a number of factors: (1) the extent to which the national Government would grant revenue-raising authorities to local government units; (2) the relative revenue base, or existing wealth of local government units; (3) differences in willingness to support family planning; (4) competition from other social welfare needs; and (5) future economic growth.

Private Sector Support. With respect to *financial* sustainability, although NGOs expended their own resources for many of the family planning activities they supported, a large percentage of their budgets came from external sources, particularly for recurrent costs. With a stagnant economy and so many Philippine families below the poverty line, there has been little scope to recover program costs from many of the poorer households. In general, both Government officials and leaders of private-sector interest groups have felt that requiring users to pay for contraceptive supplies and services would be counterproductive. However, in recent years, some NGOs operating clinics and dispensing contraceptive supplies adopted the practice of asking for contributions from clients, despite uncertainty about their legal right to charge for contraceptives that were available to them free. Fixed-fee schedules have not been the norm.

User fees are important to sustainability to the degree that fees are able to replace financial support from the public sector and the donor community. Up to 1988, there was little indication that charging fees would prove a significant source of such substitute funding.

Summary of Program Financing and Expenditures. In summary, expenditures for family planning were much reduced in the late 1980s, relative to historical trends, international norms, and the country's needs. Contributions from

external sources were drying up as donors waited for the Philippine Government to establish policy guidelines and determine the relative roles and authority of POPCOM and the Department of Health. *Considering all elements of the situation at the end of 1988, a score of 3 was assigned to this factor.*

Training

The CDIE sustainability study found that in most of the countries studied, programs with strong training provisions tended to be sustained and those without this emphasis tended not to be sustained.

A review of the L-M program effectiveness scoring as applied by the "knowledgeable observers" employed by Lapham and Mauldin, shows that training received the second highest score. This was because large *numbers* of people were trained. But there were certain *quality* problems: many trainees did not comprehend the differences in health benefits related to various contraceptive methods, many supervisors were not trained in management skills, and very few clinical staff were given preservice training.

The 1990 CDIE sustainability study (Godiksen) noted that "Training produces human resources, who, if they *continue to serve* [emphasis added] in positions where they can use their skills, generally continue to perform the activities and provide the benefits that they did during the life of the project."

The record shows that over the years, and particularly as POPCOM's influence and authority began to lessen, attention to training needs gradually diminished. Training funds, averaging P18 million annually in the early 1980s, dropped to below one-fourth of that level in 1987 and 1988, almost disappearing by 1989. This was an unfortunate lapse, because of the departure of many better trained workers. While some of the loss was due to normal attrition, many doctors and nurses left the Philippines for foreign jobs. Some of these health professionals had been employed in Outreach. Although no good analysis of attrition of family planning workers came to light, a 1988 UNFPA study showed that of those individuals currently employed, only 40 percent of physicians and nurses and 53 percent of midwives had taken courses in family planning. Four-fifths of all workers surveyed by UNFPA indicated a desire for more training (UNFPA 1988). *Given these findings, the conclusion was to assign a score of 3 to this factor.*

Mutually Respectful Negotiation Process

The 1990 CDIE study of sustainability (Godiksen) pointed out that if host Government officials felt that a program had been imposed by A.I.D., that program was less likely to be sustained than those that were designed and approved in a "...mutually respectful negotiation process involving give-and-take...." The investigators asked

> After decades of assistance experience, why do donors fail to respect the basic principle of collaboration which is consistent with...policy and the advice of experts for implementing effective projects, regardless of their potential for sustainability? The two most frequent explanations [for A.I.D.] seem to be [officers] who are overzealous advocates for particular projects (either because of personal or professional convictions, or, probably more frequently, because they are responding to the Agency incentive structure—directives from internal management or external constituents; e.g., Congress), and those who are faced with pressure from deadlines for project approval and obligation objectives. (Godiksen 1990).

In conversations with Philippine officials who had been associated with the national family planning program from its inception, and who had worked with successive A.I.D. Mission officers assigned to family planning assistance activities, the team sought evidence of overzealous, single-minded advocacy of A.I.D. agendas apart from what Filipinos wanted. These officials reported that there had been some occasions when an individual A.I.D. officer or an employee of a contractor organization had been insensitive, but that these were isolated, rare incidents. On the contrary, their memory of A.I.D. personnel working with the family planning program and projects is positive. Their experience was not of A.I.D. imposing family planning on the Philippines; rather, they recall that U.S. representatives associated with A.I.D. family planning activities for the most part made an effort to be supportive, responding to priorities established by Filipinos.

In fact, if there was a single major criticism made of A.I.D.'s role, it was that the Agency was inconsistent in its personnel appointments, not always furnishing well-qualified specialists in sufficient number to work with the Government and the NGOs in managing A.I.D. project activities. For example, one of the findings of the 1986 evaluation of PP III was that the "population staff" of USAID/ Philippines, which had been large and energetic if not activist, had reached critically low numbers by the time of that evaluation. The conclusion was that the staff was simply not adequate to manage PP III or "...to do the continuing

development work that the A.I.D. Mission should be doing in population in the Philippines." Personnel reductions had resulted in the staff focusing almost exclusively on formal project administration, which all too often had the connotation of rule enforcement. The evaluators pointed out that "...USAID staff should have the possibility of serving as advisors, not just enforcers of fiscal and procurement regulations."

The specialist who prepared the background paper for the Philippines field study concluded that Mission personnel reductions may have resulted in communication problems between USAID/Manila and POPCOM, such that the informal dialogue and contact that would normally have been critical ingredients in any successful A.I.D. effort had fallen by the wayside, and some problems that might have been forestalled had been turned into formal exchanges and counterexchanges between POPCOM and USAID/Manila. *Family planning program sustainability was not inhibited by this factor, and a score of 4 was assigned.*

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